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ABSTRACT

A hearing was held for the purpose of receiving testimony about alternative reproductive technologies and their implications for children, families, and society. Testimony provided: (1) a comparison of in vitro fertilization and gamete intrafallopian transfer, and trends in in vitro fertilization; (2) a summary of definitions, statistics, and the human and financial costs of infertility; (3) an argument for addressing underlying social causes of infertility; (4) a discussion of the Vatican's position on the human dignity of the child and the integrity of marriage and the family, and application of these principles to federal policy on in vitro fertilization; (5) an exploration of the implications of married couples' rights to reproduce coitally in relation to rights of infertile couples to use noncoital techniques to procreate; (6) recommendations for state and federal legislation; (7) a consideration of the role of federal and state laws and how they should develop in relation to knowledge about alternative reproduction; and (8) arguments against contraception and abortion. Included are articles on noncoital reproduction and the law, and on implications of a constitutionally protected right to procreate for a wide range of reproductive choices made possible by noncoital reproductive technologies. Fact sheets submitted by the committee minority are included. (RH)

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ALTERNATIVE REPRODUCTIVE TECHNOLOGIES: IMPLICATIONS FOR CHILDREN AND FAMILIES

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MAY 21, 1987

Printed for the use of the
Select Committee on Children, Youth, and Families

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ALTERNATIVE REPRODUCTIVE TECHNOLOGIES: IMPLICATIONS FOR CHILDREN AND FAMILIES

THURSDAY, MAY 21, 1987

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The select committee met, pursuant to call, at 9:35 a.m., in room 2203, Rayburn House Office Building, Hon. Bruce A. Morrison presiding.

Members present: Representatives Morrison, Lehman, Weiss, Levin, Rowland, Evans, Coats, Bliley, Johnson, Packard, Hastert, Holloway and Grandy.

Staff present: Ann Rosewater, staff director; Anthony Jackson, professional staff; Lisa Naftaly, research assistant; Carol Statuto, minority deputy staff director; Spencer Hagen Kelly, minority research assistant; Evelyn Anderes, staff assistant; and Joan Godley, committee clerk.

Mr. Morrison. I call the hearing to order. Today, the Select Committee on Children, Youth and Families will consider some of the most far-reaching and complex issues facing our Nation today, alternative reproductive technologies and their implications for children, families and for society.

In recent decades, the pace of progress in reproductive technology has been nothing short of phenomenal. Artificial insemination, first used nearly 40 years ago, now results in as many as 10,000 births each year. The first test-tube baby, a product of in vitro fertilization, arrived less than ten years ago. There have been over 2,000 more such births since then.

Surrogate mothers have given birth to over 500 babies since the late 1970s. Many of the fundamental ethical and legal issues raised in the highly publicized "Baby M" case will be discussed in our hearing today.

On the cover of this month's Life Magazine is the first host-uterus baby, a child born with no genetic link to the woman who bore her. And, as we will learn today, new medical and technological advancements in reproduction will continue to emerge, challenging our most fundamental concepts of parenthood, child-rearing, civil rights and moral authority.

These stunning changes in reproductive technology came at a time of, and to some extent are propelled by, dramatic changes of demographics of parenthood. For a variety of reasons—the overwhelming costs of child-rearing for young couples; delay in the age of first marriage; increases in the number of working women and the difficulty of juggling work and family life, given current workplace policies—couples have increasingly delayed having their first child until their late 20s and early 30s. The chances of infertility increase significantly as childbearing is delayed. Nationally, about 15 percent of all couples are infertile. However, among couples 30 to 34, the infertility rate is more than 50 percent greater than the rate for couples 25 to 29.

Since 1968, the demand for treatment for infertility has more than tripled, from 600,000 couples to over 2 million. For these young couples, and increasingly for older, single women who seek to be parents, alternative reproductive technologies represent hope, for some the only hope, of a genetically related baby. Yet, these technologies also force us to question what we as a society consider to be acceptable, to be equitable, to be legal, and to be sacred.

Should we focus resources on producing children through expensive technological methods when thousands of children await adoption, and when the children of low-income families suffer from inadequate prenatal health care and nutrition? What impact will these new methods of reproduction have on the health and well-being of the children as they grow and develop? Will their family lives be markedly different? Does the commercialization of human reproduction violate our most fundamental laws against trade in human beings, or are these arrangements protected by Constitutional guarantees of the freedom to procreate?

How do we treat the fine line between reproductive choice for women and the risk of economic exploitation? What role is appropriate or necessary for government on any level to take, as scientific discoveries outpace and potentially alter our social and legal framework?

No more fundamental issues could ever come before the Congress. Today's witnesses are the most prominent researchers, attorneys and clinicians in the field of alternative reproduction. They have been selected deliberately to present the range and divergence of opinion on these issues. It is only through this kind of open give and take that we will close the gap between the new technologies available for human reproduction and the social and moral consequences of the application of these technologies.

[The opening statement of Hon. Bruce Morrison follows:]

Opening Statement of Hon. Bruce Morrison, a Representative in Congress From the State of Connecticut

In recent decades, the pace of progress in reproductive technology has been nothing short of phenomenal. Artificial insemination, first used nearly 40 years. ago, now results in as many as 10,000 births per year.

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These stunning changes in reproductive technology come at a time of—and to some extent are propelled by—dramatic changes in the demographics of parenthood.

For a variety of reasons—the overwhelming costs of childrearing for young couples, delay in the age of first marriage, increases in the number of working women and the difficulty of juggling work and family life given current workplace policies—couples have increasingly delayed having their first child until their late 20's and early 30's.

The chances of infertility increase significantly as childbearing is delayed. Nationally, about 15 percent of all couples are infertile, however, among couples 30 of 34 the infertility rate is more than 50 percent greater than the rate for couples 25–29. Since 1968, the demand for treatment for infertility has more than tripled, from 600,000 couples to over 2 million.

For these young couples, and increasingly for older single women who seek to be parents, alternative reproductive technologies represent hope—for some the only hope—of a genetically related baby. Yet these technologies also force us to question what we, as a society, consider to be acceptable, to be equitable, to be legal, and to be sacred.

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It is only through this kind of open give-and-take that we will close the gap between the new technologies available for human reproduction, and the social and moral consequences of the application of those technologies.

Mr. MORRISON. I have a statement to submit for the record from Congressman George Miller, Chairman of the Select Committee.

[Prepared statement of Hon. George Miller follows:]

PREPARED STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Today, the Select Committee on Children, Youth and Families will examine the current and emerging reproductive treatments and explore the complex medical, legal and ethical questions these methods pose for our society, as well as our children and families. I am especially pleased that my colleague from Connecticut, Bruce Morrison, requested that we conduct this hearing.

For a variety of economic, cultural and social reasons, many of today's couples are getting married later and are postponing childbearing. But often, just when they feel financially and personally ready to start a family, many find that they are not able to have children.

In the past decade, medical discoveries have provided hope for the 15% of married couples in the U.S. who are infertile. While generally a last resort, these new procedures—including artificial insemination, in vitro fertilization, surrogate motherhood, embryo transfer and host uterus arrangements—have made it possible for many infertile couples to have children.

These methods may solve many problems, but they also raise complex legal and moral dilemmas. As the highly publicized Baby M. case made evident, the technology of infertility treatment has, in some instances, surpassed society's ability to assimilate it, forcing us to confront some very basic, very delicate questions.

For instance, should there be limits to the means by which infertile couples may create families? What does it mean to be a "mother" when one woman carries the baby and another raises it? What are the parental rights and responsibilities of those who use third party methods? Are the answers to these questions different from those in the case of adoption?

Do these new techniques pose significant health or emotional risks for women or should women be free to choose whether they will undergo infertility treatments or bear another couple's child? How do we resolve the potential inequities for low and middle income couples who cannot afford these treatments, let alone pre-natal care during traditional pregnancies?

Most importantly, what are the physical and emotional risks to children born of these technologies?

Based on Congress' past record when considering issues of morality, religion and personal values, I view the movement of government into these sensitive areas with trepidation. Still, since neither the demand for infertility services nor the progress of science show signs of abating, state and federal legislators will have to confront the medical and legal challenges of reproductive technology.

The Select Committee, because it is not a legislative committee, has the unique luxury of considering topical and controversial issues, not in the context of a particular statute, but as policy questions which demand future enlightened consideration. In particular, it can examine those issues, like reproductive technology, which have the potential to change the meaning of parenthood and the dynamics of childhood in the country and around the world.

I look forward to the insights that our expert witnesses can provide today on what is sure to be a matter of public policy debate in the months to come.

Mr. MORRISON. The gentleman from Indiana has a statement?

Mr. COATS. I thank the Chairman. I think that statement that you just read is certainly an excellent one and defines the scope of what we're attempting to do with this hearing. There are a number of unanswered questions. We have experts here today that hopefully can give us some of those answers. There are a number of ethical questions and moral questions involved in this whole area. Hopefully, we can enter into a good discussion as to what some of those are, and point the way in terms of dealing with those.

All of us, I think, want to advance these new technologies to the point where we can offer promise for infertile couples, and we can bring about positive advances in the ability of couples to form their family. And yet, there are risks involved and there are many ethical questions involved in terms of extending this beyond the traditional family concept and using it in ways which may not be appropriate.

So, I commend the Committee for moving forward with this exploration in an area where there are many, many unanswered questions, and hopefully we can provide a basis for us to make sound decisions in the future. I look forward to hearing from the witnesses.

Mr. MORRISON. Thank you.

Does the gentlelady from Connecticut have a statement?

Mrs. JOHNSON. Thank you. I commend you, Mr. Chairman, on your opening statement. Advances in reproductive technology pose profound questions and difficult choices for women. I believe women must have the right and the power to answer these questions and make their choices. But it is of the utmost importance that within our society we elucidate the issues, do the research, do the discussion that will help all of us, men and women, in our society, to focus on the challenging advances in reproductive technology posed to all of us.

I commend the Committee for calling this hearing today.

Mr. MORRISON. I'd like to call the first panel of witnesses. Gary D. Hodgen, Ph.D., Scientific Director of the Jones Institute for Reproductive Medicine in Norfolk, Virginia; Robert J. Stillman, Medical Doctor, Associate Professor and Director of the Division of Reproductive Endocrinology and Fertility, the George Washington University Medical Center in Washington, D.C.; Wendy Chavkin, Medical Doctor, Director of the Bureau of Maternity Services and Family Planning of the New York City Department of Health, New York, New York; Richard Doerflinger, Assistant Director for Pro-Life Activities, National Conference of Catholic Bishops, Washington, D.C.

If those four witnesses would take their place at the witness table, I'd appreciate it.

I'm going to ask you to testify in the order of your introduction. Dr. Hodgen, I know that you have to leave early, so with the indulgence of my colleagues, we will hear your testimony and direct our questions to you first, before hearing from the remainder of the panel.

With respect to all of you, your written submissions are made part of the record and you may proceed to summarize those in the way you find most effective.

So, Dr. Hodgen, if you would begin.

STATEMENT OF GARY D. HODGEN, PH.D., SCIENTIFIC DIRECTOR, THE JONES INSTITUTE FOR REPRODUCTIVE MEDICINE, PROFESSOR OF OBSTETRICS AND GYNECOLOGY, EASTERN VIRGINIA MEDICAL SCHOOL, NORFORK, VA

Mr. Hodgen. Thank you. First, allow me to express my appreciation for the opportunity to address the Committee on this important issue.

I prepared a written statement of approximately three pages, which I will summarize briefly.

Among the principal life objectives of most adults in America is the founding of a family. Having children in a number and at a time suited to the couple's plans and aspirations is highly desirable.

Frequently, passing one's genes to the next generation is a strong motivation and significant part of the marriage relationship and the family experience, as are pregnancy and parenting.

However, the nurturing of children, youth and adults within the structure of family can be compromised when severe developmental defects afflict fetuses, children and youth. Thus, fertility, contraception and congenital normalcy are high priorities for the family.

These are powerful forces driving patients to seek medical services for human reproduction. Increasingly, the needs expressed by patients persuade scientists and physicians of the need for reproductive research in the laboratory and the clinic, to achieve successes in infertility treatment, safe and reliable contraception and assurance that the children born into the family will be healthy.

The accelerated emergence of the new reproductive technologies reflects these pressures in biomedical science and health care delivery.

We're going to compare briefly two procedures—in vitro fertilization in which the egg and the sperm are combined in a laboratory dish, allowed to undergo fertilization there and then after about two days, as the embryo progresses in its development, usually to approximately the four-cell stage, those embryos are returned to the uterus. In the other procedure, gamete intrafallopian transfer, the gametes are also collected in the same or similar way, but they are put into the fallopian tube so that fertilization can occur there. The difference is really in the patient population.

In the first case of in vitro fertilization, most of the patients do not have functional fallopian tubes, or no tubes at all, due to ectopic pregnancy, disease, or congenital defects. In the case of gamete intrafallopian transfer, which I call GIFT, the patient must have a fallopian tube that can serve as recipient for the gamete.

Since the 1978 birth of Louise Brown in Oldham, England, and of Elizabeth Carr, America's first IVF baby in Norfolk, Virginia in 1981, IVF and embryo transfer has matured from an experimental, therapeutic procedure to an effective and widely applied infertility treatment. As illustrated in Appendix B, I have estimated that the current number of IVF programs worldwide is approximately 220, with about 75 active IVF programs in the United States.

Perhaps up to 50 additional IVF centers in the U.S.A. may be established within the next 24 months. Many IVF programs have been developed successfully in association with different types of institutions, including medical schools and their affiliated hospitals, private clinics, and certainly community hospitals.

Among well-developed IVF programs, pregnancy rates have risen steadily over the past five years into the range of 20 to 30 percent. In the Norfolk program, the IVF team has achieved 27 to 31 percent pregnancy rates consistently from 1985 to the present time, despite numerous difficult cases.

As shown in Appendix C, using current capabilities, each 1,000 treatment cycles results in the birth of approximately 230 babies. Importantly, the cumulative pregnancy rate, after three treatment cycles, exceeds 50 percent. An additional treatment method, GIFT, also has proven effective and was developed in San Antonio, Texas and more recently, in Irvine, California.

By the end of 1987, more than 5,000 children worldwide, nearly 1,000 of these from the United States, will have been conceived and born by these new reproductive technologies.

Noting that the Earth's human population reached 5 billion persons in 1986, we can already see that one in one million humans living today was conceived by these technologies.

I will talk only briefly about the areas into which in vitro fertilization is moving either recently, or imminently soon.

These are on the threshold of clinical application and research to bring capabilities into the clinic. The first of these is donor egg treatment, where donated eggs have been provided to recipient women either unable to use their own eggs or women lacking ovarian function, such as premature menopause. A woman may only be 25 or 30 years of age, but the physiology of her ovaries is that she is post-menopausal in her state.

By giving these women replacement hormonal therapy, the uterus can be prepared to accept the embryo implant and carry the pregnancy.

Usually, the donated eggs derive from generous, consenting IVF patients having extra eggs that are provided anonymously for fertilization in vitro by the sperms of the husband and the recipient woman. Subsequently, the embryos are transferred to the recipient's uterus.

Moving next to cryopreservation, or freezing of embryos. Increasingly, embryo freezing is being evaluated as an adjunctive technique, both to conserve embryos and to reduce the risk of multiple pregnancy when several embryos may have been available to transfer about two days after fertilization.

Although many IVF programs in the United States have stored embryos by freezing, the technique is still experimental and requires additional research to improve success.

The next issue is surgical fertilization of the egg. This is intended to help infertile men rather than infertile women.

Among couples seeking IVF therapy are infertile men who either produce reduced numbers of sperm which we call severe oligospermia, or they may be men that have significant numbers of sperm but these sperms are unable to fertilize their wives' eggs. A micropipet may allow microscopic surgical placement of the single sperm into the egg thereby achieving fertilization and embryonic development. Notice that establishing this treatment method would necessarily create embryos as a product of the research.

Moving next to oocyte freezing. Oocyte freezing is important because it has many fewer ethical problems than does freezing of embryos. Some scientists are concerned that the fragile state of the egg's chromosomes will make them intolerant of the rigors of freezing and thawing which could produce developmental anomalies. Thus, some investigators have advocated thorough chromosomal analysis of resulting embryos before attempting transfer of such embryos for pregnancy. Again, this raises the issue of embryo use for research rather than pregnancy.

The next issue I've touched on only briefly in these verbal remarks but more at length in the written statement. It deals with the prevention of congenital and developmental abnormalities as related to these new reproductive technologies.

By using a technique called restriction fragment length polymorphism, special enzymes called endonucleases can cut the DNA from a biopsy of the embryo, a few cells taken off the embryo which does not harm the embryo's ultimate development, and examine the DNA for genetic normalcy. Ribbons of DNA being longer or shorter allow one to diagnose that if this embryo were to become a child, the child would be normal or defective with a specific genetic disorder.

Diseases that could be detected in this way are so-called single gene defects. Examples are sickle cell anemia, Huntington's chorea, cystic fibrosis and Betathalesemmia. There are, however, 3,000 such diseases known. Yet when comparing the ethical problems in using such a technique, we have to also consider the human suffering and the cost to affected families emotionally and economically, we must consider that alternative therapeutic abortion after gestational diagnosis by chorionic villus biopsy and amniocentesis are also in some cases acceptable procedures. This would be a diagnosis, you see, before the embryo was ever transferred to the uterus.

The last issue I want to touch upon is the relationship of these new reproductive technologies to contraception and family planning.

Perhaps no single issue affects the lives of women and children the world over so profoundly as a couple's access to safe and effective means to space the births of their children. This is no less true in the United States.

Human sexuality is expressed in so many ways that new choices for contraception are needed. Some factors to consider in new contraceptive options are safety, reliability, cost, convenience, and conservation of subsequent fertility. Inherently coexistent with contraception is the priority of preventing infection from heterosexually transmitted diseases which often risk female infertility later because of pelvic inflammatory diseases, and tragically, even AIDS.

Among the teenage population, pregnancy continues to stifle education, markedly impair the opportunities of life for adolescent women and their children born too soon.

New reproductive technologies offer a part of the solution to this problem. But we emphasize, a part of it, along with education about human sexuality and moral behavior.

The public's loss of confidence in the intra-uterine contraceptive device has diminished a major family planning method used by many women. Among women over 35 years of age, who may not yet be to the menopause, the oral contraceptive is often contra-indicated because of side effects. These women have to make other choices.

For men, condoms or surgical sterilization may not be acceptable. And certainly there are limitations to other methods which include spermicides and other means of blocking access of the sperm to the egg.

Since the number of elective abortions in the United States exceeds 1.5 million per year, surely the development of more effective and acceptable means of contraception should be a high priority in developing new reproductive technology. I am especially enthusiastic that we should pursue as a nation methods that block gamete interaction—that is, the means by which fertilization occurs. The egg and the sperm must join physically in order to initiate the new person. In vitro fertilization, you see, provides a means to study this process in the laboratory, to learn how we can prevent the egg and the sperm from uniting in such a way as to cause fertilization and development.

It is apparent that IVF lends itself to this important research opportunity, but brings ethical questions of justification.

Simultaneously, we must link effective contraception to the prevention of AIDS transmission between men and women. Thus, barrier methods and virucidal agents seem attractive possibilities.

To conclude my statement, a paragraph about the issue of stewardship and the public trust.

Ethical considerations of social responsibility in development of the new reproductive technologies have gained increasing attention in recent years. The level of medical practice—in the level of medical practice there are questions about quality control for therapeutics. Not all of the IVF programs do as well as others. Patients need to be honestly told what their opportunities to gain a child may be.

Regarding research directions, there are questions about priorities, limits, review and oversight procedures, and especially, the amount of respect and value accorded to the human embryo.

At the same time, it is recognized that sound, basic research must continue. These issues and public policies require even more attention when we think about the problems of cost and fairness, such that many families, people who would like to have families in fact in this case, of modest economic means, cannot go to the medical community and gain these services. They're not affordable.

I leave you with three recommendations to consider. The priorities of the Select Committee seem paramount to me in the following way.

First, a national policy on guidelines that provide some degree of uniformity. I would ask you to consider in fact that in joining the Secretary of DHHS to consider implementation of the recommendations of the Ethics Advisory Board that were published in 1979; many cases are still suited to our situation today; other things require revision.

Second, an enhanced dialogue between the lay public and the involved physicians and scientists so that ethical, religious and legal concerns can be understood alongside determination of meritorious scientific studies aimed toward imminent medical breakthroughs. And here I would ask for the appointment of a new ethics advisory board so that we could look at a modern way, as you've made in your opening remarks the statement, how fast this field has moved; it needs to be looked at again very carefully.

Finally, then, the third recommendation is to require the availability of some insurance coverage to assist families of modest economic means to have well children and youth.

The public's trust in the miracles of biomedical research during the 20th century is the largest single reason for our successes in health care. As the stewards of this irreplaceable confidence, we must see that the public's trust in scientific research will be preserved for the families of the 21st century.

Thank you very much.

[Prepared statement of Gary D. Hodgen, Ph.D., follows:]

PREPARED STATEMENT OF GARY D. HODGEN, PH.D., SCIENTIFIC DIRECTOR, THE JONES INSTITUTE FOR REPRODUCTIVE MEDICINE, AND PROFESSOR OF OBSTETRICS AND GYNECOLOGY, EASTERN VIRGINIA MEDICAL SCHOOL, NORFOLK, VA

Attached: Appendix A: Milestones of the Jones Institute for Reproductive Medicine

Appendix B: Scope of IVF/ET Clinics

Appendix C: Success Rates for IVF/ET Therapy

Principle Reference: Ethical Considerations of the New Reproductive Technologies. Fertility and Sterility 40: Supplement-1, 1986
Published by The American Fertility Society
2131 Magnolia Avenue, Suite 201
Birmingham, Alabama 35282-9990

Introduction

Among the principal life objectives of most adults in America is the founding of a family. Having children in a number and at a time suited to the couple's plans and aspirations is highly desirable. Frequently, passing one's genes to the next generation is a strong motivation and significant part of the marriage relationship and family experience, as are pregnancy and parenting. However, the nurturing of children, youth and adults within the structure of family can be compromised when severe developmental defects afflict fetuses, children and youth. Thus, fertility, contraception and congenital normalcy are high priorities for families.

These are powerful forces driving patients to seek medical services for human reproduction. Increasingly, the needs expressed by patients persuade scientists and physicians of the need for reproductive research in the laboratory and clinic to achieve success in infertility treatment, safe and reliable contraception, and assurance that children born into the family will be healthy. The accelerated emergence of the new reproductive technologies reflects these pressures in biomedical science and health care delivery.

In Vitro Fertilization (IVF) and Embryo Transfer (ET) and Gamete Intrafallopian Transfer (GIFT)

Since the 1978 birth of Louise Brown in Oldham, England and of Elizabeth Carr, America's first IVF baby, in Norfolk, Virginia in 1981, IVF/ET has been matured from an experimental therapeutic procedure to an effective and widely applied infertility treatment. As illustrated in Appendix B, I have estimated that the current number of IVF programs worldwide is approximately 220, with about 75 active IVF programs in the U.S.A. Perhaps up to 50 additional IVF centers in the U.S.A. may be established within the next 24 months. Many IVF programs have been developed successfully in association with different types of institutions, including medical schools and their affiliated teaching hospitals, private clinics, and in community hospitals.

Among well-developed IVF programs, pregnancy rates have risen steadily over the past 5 years into the range of 20 to 30%. In the Norfolk program, the IVF Team has achieved a 27 to 31 % pregnancy rate consistently during 1985 to 1987, despite numerous very difficult cases referred to Norfolk by other IVF and infertility treatment centers. As shown in Appendix C, using current capabilities, for each 1000 treatment cycles about 230 babies will be delivered. Importantly, the cumulative pregnancy rate after three (3) IVF treatment cycles exceeds 50%. An additional treatment method, GIFT, also has proven effective in some groups of patients, as developed in San Antonio, Texas and Irvine, California. By the end of 1987 more than 5000 children worldwide (nearly 1000 of these in the U.S.A.) will have been conceived and born by these reproductive technologies. Noting that the earth's human population reached five (5) billion persons in 1986, the new reproductive technologies now account for about 1/1,000,000th of the total human population living today (Appendix C).

Donor Egg Treatment

Donated eggs have been provided to recipient women either unable to use their own eggs or to women lacking ovarian function, but receiving replacement hormonal therapy to prepare their uterus for implantation and pregnancy. This technique was pioneered by research at The Jones Institute in Norfolk and is now used worldwide. Usually, donated eggs derive from generous consenting IVF patients having extra eggs that are provided anonymously for fertilization _in vitro_ by sperms from the husband of the recipient woman; resulting embryos are then transferred to the recipient's uterus. Sometimes the donor is a close relative, such as a sister. More than 30 children have been born using donor egg therapy.

Cryopreservation of Embryos

Although in the Norfolk program we have not relied upon it, increasingly, embryo freezing is being evaluated as an adjunctive technique, both to conserve embryos and to reduce the risk of multiple pregnancy when several embryos may be available for transfer about 2 days after fertilization of the eggs. In Australia and Europe about 60 children have been born from the transfer of thawed embryos. Here in the U.S.A., the first such birth occurred in Los Angeles, California in 1986. Although many IVF programs in the U.S.A. have stored frozen embryos, the technique is still experimental and requires additional research to improve success.

Surgical Fertilization of the Egg

Among couples seeking IVF therapy are infertile men who either produce a reduced number of sperm (severe oligospermia) or may have large numbers of sperm, but they are unable to fertilize their wife's eggs even _in vitro_. Results from animal experiments suggest that a micropipet may allow microscopic surgical placement of a single sperm into an egg, thereby achieving fertilization and embryonic development. Notice that establishing this treatment method would necessarily create embryos as a product of the research.

Oocyte Freezing

Having the capability to freeze eggs for storage and later use would obviate much of the need to freeze embryos, therein reducing the ethical and legal dilemmas inherent to cyropreservation of human embryos. However, some scientists are concerned that the fragile state of the egg's chromosomes will make them intolerant of the rigors of freezing and thawing which could produce developmental anomalies. Thus, some investigators have advocated thorough chromosomal analysis of resulting embryos before attempting transfer of other such embryos for pregnancy. This raises the issue of embryo use for research rather than pregnancy.

Prevention of Congenital and Developmental Abnormalities

In the founding of a family, perhaps the greatest gift to any parent is having well children who can grow and develop into successful youth and adults. Unfortunately, congenital defects rob millions of families, including mothers, fathers and well siblings of their rightful claim to a normal, nurturing family. The emotional and economic burdens can be unbearable. Yet, the cost is highest for the afflicted child, whose potential may be largely sacrificed in a life severely compromised or truncated by developmental anomalies.

An extension of IVF may soon allow development of diagnostic tests that can determine whether an embryo is genetically flawed in regard to some specific heritable disease. Research on animal embryos suggests that an embryo biopsy taken before embryo transfer will allow detection of abnormalities in the DNA even before expression of the gene while not harming the developmental potential of these embryos. By using a technique called restriction fragment length polymorphism (RFLP), special enzymes (endonucleases) cut the DNA from the biopsy cells into longer and shorter ribbons that can be identified as normal or defective. Diseases that could be detected in this way are so-called single gene defects, such as sickle cell anemia, Huntington's chorea, cystic fibrosis, and B-thalesemmia. More than 3000 such genetically heritable diseases are known. The quandaries as to whether and how research should proceed are both obvious and formidable. Yet when comparing the human suffering and cost to affected families, or alternatively therapeutic abortion after gestational diagnosis by villus biopsy or amniocentesis, this new reproductive technology deserves consideration as important research.

Contraception and Family Planning

Perhaps no other single issue affects the lives of women and children world over so profoundly as a couples access to safe and effective means to space the births of their children. This is no less true in developed countries, including the U.S.A. Human sexuality is expressed in so many ways that new choices for contraception are needed. Some factors to consider in new contraceptive options are: safety, reliability, cost, convenience and conservation of subsequent fertility. Inherently coexistent with contraception is the priority of preventing infections from heterosexually transmitted diseases which often risk female infertility later because of pelvic inflammatory diseases or, tragically, even AIDS (HIV).

Among the teenage population, pregnancy continues to stifle education and markedly impairs the opportunities of life for adolescent women and their children, born too soon. New reproductive technologies offer a part of the solution to this problem, along with education about human sexuality and moral behavior.

The public's loss of confidence in the intrauterine contraceptive device (IUD) has diminished a major family planning method formerly used by many women. Among women over 35 years of age, but not yet to menopause, the oral contraceptive may be contraindicated because of side affects that increase in frequency with advancing age. For men condoms or surgical sterilization may not be acceptable to some, as some women object to tubal ligation. Certainly, reversibility to regain fertility after surgical contraception is often not successful. Likewise, spermicides and diaphrams have significant limitations. Since the number of elective abortions in the U.S.A. exceeds 1,500,000 annually, surely development of more effective and acceptable means of contraception should be a high priority in developing new reproductive technologies.

I am especially enthusiastic that we should pursue research on methods that block gamete (sperm-egg) interaction, thus preventing fertilization without systemic effects on the body as a whole. It is apparent that IVF lends itself to this important research opportunity, but brings ethical questions of justification. Simultaneously, we must link effective contraception to prevention of AIDS transmission between men and women. Thus, barrier methods and virucidal agents seem attractive possibilities.

Stewardship of the Public's Trust in Research

Ethical considerations of social responsibility in development of the new reproductive technologies have gained increasing attention in recent years. At the level of medical practice, there are questions about quality control for therapeutic services at some IVF clinics. Regarding research directions, there are questions about priorities, limits, review and oversight procedures, and especially about the respect and value accorded the human embryo. At the same time it is recognized that sound basic research should continue. These issues of public policy require even more attention when cost and fairness are considered in the restricted availability of medical care in the form of new reproductive technologies.

Three priorities for this Select Committee seem paramount: 1) a national policy on guidelines that provide some uniformity; 2) an enhanced dialogue between the lay public and the involved physicians and scientists so that ethical, religious and legal concerns can be understood alongside determination of meritorious scientific studies aimed toward eminent medical breakthroughs, and 3) required availability of some insurance coverage to assist families of modest econonmic means to have well children and youth.

The public's trust in the "miracles" of biomedical research during the 20th century is the largest single reason for our successes in health care. As the stewards of this irreplaceable confidence, we must see that the public's trust in scientific research will be preserved for families of the 21st century.

Appendix A

The Jones Institute for Reproductive Medicine was founded by Drs. Howard and Georgeanna Jones and Dr. Mason Andrews in the Department of Obstetrics and Gynecology, The Eastern Virginia Medical school during the 1983-1984 academic year.

Just three years earlier, the U.S.A.'s first IVF program was created in Norfolk, resulting in the birth of Elizabeth Carr during December 1981, the first IVF baby conceived and born in America.

Presently, the Norfolk IVF program is directed by Dr. Zev Rosenwaks. This IVF team of more than 40 physicians, scientists, nurses, technicians and administrative staff performed more than 500 IVF treatment cycles in 1986, making it the largest IVF program in the U.S.A. More than 300 children have been born from the Norfolk IVF program. The Vth World Congress of IVF/ET met in Norfolk, Virginia during April 5-10, 1987, with 1300 scientists and physicians in attendance.

In 1986, the Jones Institute was competitively awarded the $28,000,000 five-year Contraceptive Research and Development (CONRAD) grant from the U.S. Agency for International Development. Dr. Gary Hodgen is the program director, working with a staff of scientists, physicians, technicians, nurses and administrators to develop new contraceptive methods, with emphasis on less developed countries.

Appendix B

IVF/ET STATUS: 1987

Worldwide Scope of IVF Clinics

Number of Clinics*		Number of Treatment cycles/year
20	large	500
50	medium	200
50	small	100
100	beginning	50
220	This multiples to =	30,000 annually

* 75 active in U.S.A.; up to another 50 are under development

Assuming 5 oocytes are inseminated for each treatment cycle, 150,000 eggs may be exposed for fertilization *in vitro*/year.

[Since no formal data base exists, these are "best estimates" based on informal knowledge.]

Appendix C

IVF/ET STATUS: 1987

5 Billion persons living (1986)
* 5000 children born by IVF and GIFT worldwide
1/1,000,000th of the human population has been conceived by IVF and GIFT

*almost 1000 of these are from the U.S.A.

Success Rates for IVF/ET

per 1000 treatment cycles reaching embryo transfer
5000 oocytes
5000 inseminations
4500 embryos (multiple embryos transferred)
250 pregnancies (confirmed fetus *in utero*)
200 deliveries (some lost to spontaneous miscarriage)
230 children (some multiple pregnancies)

[Since no formal data base exists, these are "best estimates" based on informal knowledge.]

Mr. **Morrison**. Thank you, Dr. Hodgen. I know that you have to leave soon. I would ask my colleagues if we could each limit ourselves to one question so that everyone here does get a chance to question Dr. Hodgen. And if that goes more quickly, we can go around for a second round.

I'd just like to ask you, you made a recommendation that we focus on the 1979 recommendations on guidelines. I take it you're recommending that there be Federal guidelines with respect to this kind of research and fertility treatment and I'd like you to at least highlight those positions that you think should be in such guidelines. In other words, those choices you think those guidelines should make, not the questions, but the answers, to the extent that you think you know what they are.

Mr. **Hodgen**. I think the values are in ensuring that people are getting in this form of medical care what it is that they're asking for, and the public at large, who may not be the infertile couples. They need to know that we're moving in the right direction, that oversight is reasonable, that things that are being done have been thought through, that they are in fact to some degree regarded by many as appropriate.

I believe the first issue then is that any research that's done in this area requires review by what we call the Institutional Review Board. You know this mechanism well, the IRB. It's the way in which lay persons working in a particular community with the physicians and scientists look at the work and decide that informed consent has been given and this has a reasonable opportunity of offering some help or in this case, reproductive benefit.

The second issue I think is in the area of public trust, to deal openly with what the motives are for the research. Why are we trying to learn what we're learning? Why is the process of scientific inquiry and health care delivery to people who need children, healthy children, how is this related?

These are the issues I would like to see brought forth by recommending some implementation of the 1979 EAB report.

Mr. **Morrison**. Thank you.

Mr. **Coats**. Doctor, you in your statement called for a recommission, I think, of the Ethics Advisory Board. There was previously an Ethics Board, was there not?

Mr. **Hodgen**. Yes, there was.

Mr. **Coats**. And that was disbanded in 1980?

Mr. **Hodgen**. That's correct.

Mr. **Coats**. Why was that disbanded, do you know?

Mr. **Hodgen**. I don't actually know why. I believe that in part it had to do with whether we wanted any further consideration in our government of this issue, but obviously I'm only guessing. I have no absolute knowledge. The expiration of the Ethics Advisory Board has a particular impact on our issue here today, and it means that if I as an investigator would submit a grant to the National Institutes of Health, it could not be considered for funding under present law until of course it had passed approval by the Ethics Advisory Board. Since there is no Board, it cannot be considered. So the door is locked to considering important research through our normal proposal, grant review and funding process.

Mr. **Coats**. Just to follow up with that question, and then quickly move on here, given our upcoming vote on the floor, you would acknowledge and concede that while you describe the procedural process that would take place in order for grants to be given and so forth, there are a number of controversial ethical questions that have to be answered, and that had something to do with the disbanding of the board and probably would have a lot to do with whether or not a new one should be formed; is that correct?

Mr. **Hodgen**. Oh, absolutely. I hope I touched on only part of them, of course, because of the brevity that's necessary here, but I couldn't agree more. I think the list is long, they are complicated, they are not easy issues to deal with, but we can all see that we're in a time and a situation in which they must be dealt with. That's why I think the appointment of a new Board may get us into a position to consider the very complex, numerous problems.

Mr. **Morrison**. The gentleman from Florida?

Mr. **Lehman**. I have no questions.

Mr. **Morrison**. The gentlelady from Connecticut?

Mrs. **Johnson**. I'd just like to clarify that last issue that you and the gentleman from Indiana were discussing.

Do I understand correctly that because there is no Board to deal with or consider the ethical issues, that there are research projects that simply can't even be considered for funding?

Mr. **Hodgen**. That's correct.

Mrs. **Johnson**. So there are whole areas of research that we are not involved in at all because we don't have the institutional mechanism to allow the grants to be funded?

Mr. **Hodgen**. I couldn't say it so well.

Mrs. **Johnson**. And what kinds of, what categories of grants——

Mr. **Hodgen**. These would be grants for example looking at whether and how we should for example develop this method of surgical fertilization of the egg. That's an example. Another would be if we could develop a contraceptive that wouldn't have side effects, that doesn't cause in a woman high blood pressure and blood clots and all the other things that we worry about with oral contraceptives. We would be able, if the proposal were sufficiently meritorious scientifically, and was thought ethical by the Review Board, then the funding would allow the research perhaps to develop methods by which we can look at the egg and the sperm together in the laboratory and determine by this direct process whether we have blocked fertilization at that level, and get away then from systemic methods that have side effects.

Mrs. **Johnson**. Has the initiative in research in implantation moved from the United States to other nations because of the lack of this Board or what role has the lack of this Board played in this transference of leadership in this important area from the United States to England and other countries?

Mr. **Hodgen**. I think the missing pieces are that the guidelines that we're working by which are informally those of the American Fertility Society which took upon itself the professional responsibility to look at this issue involving people outside the medical profession to assist in making the decision—ethicists, lawyers, sociologists, etc., to assist in making the decision involved. I believe that we need to have our government do this; we need processes of uniformity. All of us look for independence among the states, but the problem is we have a policy here which is individualized according to each jurisdiction of a state. We have couples going far from where they live to receive medical services. We don't have it recognized such that insurance coverage is broadly available, and there's a great injustice and fairness about who can and cannot found a family.

Mr. **Morrison**. If I could give the other gentlemen a chance to ask questions if they have them. The gentleman from Louisiana.

Mr. **Holloway**. I don't really have a question. My doubt is where do we end Federal involvement in everything? You know, surely we had a purpose in the beginning as a Federal people and here we've pretty well in my opinion just moved out of totally what the original purpose was for us being here. And I think if we listen to the different actions from life that we would be involved in every step of every individual's life. I just personally do not feel that's what we're elected to be here for. You may have a follow up on what your belief is, but my feelings are where do we end, and where does the Federal involvement end in everyday life?

Mr. **Hodgen**. Certainly the issue of intrusion is at a very personal level here, and I couldn't disagree. I have some of the same feelings that I believe I've just heard from you. We're also dealing with the people who are coming to the medical community and saying help me have a well child. This is the tension that exists in biomedical research and in health care delivery. I definitely have feelings that I hear you express.

Mr. **Morrison**. The gentleman from Illinois.

Mr. **Hastert**. Thank you. And I appreciate your testimony. I'll try to be brief, as we do have a vote coming up. A couple things. First of all, to set some definitions in the record clear, the issue that you're talking about here is being able to, in cases of illness of couples and they can't have a baby or a child, their ability to go forward and to do actually some genetic engineering to see what the problem is in order to have a well offspring, right?

Mr. **Hodgen**. Well, it's a question whether we should. You see, the possibility exists——

Mr. **Hastert**. But the scientific method itself.

Mr. **Hodgen**. The scientific method, I wouldn't call it genetic engineering, but it's certainly determining whether the genes that are there are defective. But we have not changed or altered those genes. That's an important distinction.

Mr. **Hastert**. And what it actually does then is offer the ability to people who first of all, physically can't have children.

Mr. **Hodgen**. These people would be able to have children. May I give you a very brief example? We had here a couple, both of whom were carriers of sickle cell anemia. They themselves are healthy. But the risk is that this man and woman, one chance in four, would have an affected child. One in four. Let's say we help them, through in vitro fertilization, not because they can't conceive, because they wish to have a well child only. That really is how this would work.

Mr. **Hastert**. So in other words it does enable people who would have difficulty having children otherwise to find other methods to have those children and also would be available to people who have lived outside of a male-female type relationship marriage to have children, too. It gives them options; is that correct?

Mr. **Hodgen**. I suppose it would. We have not dealt with such situations.

Mr. **Hastert**. Is that basically the decision of those boards, to make those types of decisions?

Mr. **Hodgen**. Oh, I think so. That's a part of how we would make a judgment that something was ethically——

Mr. **Hastert**. These boards that you're talking about would have to make some pretty moral decisions.

Mr. **Hodgen**. Oh, absolutely, yes.

Mr. **Hastert**. Thank you. I appreciate we're short of time, and I realize that. Thank you very much.

Mr. **Morrison**. The hearing will recess for the members to vote and we'll be back in five or six minutes and hear from the rest of the panel.

[Recess]

Mr. **Morrison**. I apologize to the panel for the delay and I would ask you if you would each of you now summarize your testimony and then the Committee will certainly have questions for all of you.

Dr. Stillman, if you'd like to begin.

STATEMENT OF ROBERT J. STILLMAN, M.D., ASSOCIATE PROFESSOR AND DIRECTOR, DIVISION OF REPRODUCTIVE ENDOCRINOLOGY AND FERTILITY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, WASHINGTON, DC

Dr. **Stillman**. Mr. Chairman, Members of the Committee. So as not to be repetitive of Dr. Hodgen's excellent summary, I have been asked to summarize definitions, statistics and the human and financial costs of infertility in general, as a background to the deliberations of your committee on the new "alternate" reproductive technologies. I am pleased to be able to do this.

The monthly cycle in women of reproductive age is comprised of a delicate, balanced and orchestrated series of events leading to ovulation, the passing of a mature egg to the ovary. Then, transport of millions of sperm through the female reproductive tract, fertilization in vivo—i.e., in life, as opposed to in vitro, under glass—and implantation of the early dividing pre-embryo into the wall of the uterus.

If pregnancy is not achieved, the body signals the end of this reproductive cycle and the commencement of another, with menstruation, or shedding of the uterine lining. The stage is set for a repetition of this orchestration with its critical biologic aim—reproduction. Indeed, there are two basic biologic laws applying to all species and espoused by Darwin. First, that of preservation of the self and second, preservation of the species. The biologic purpose of the reproductive cycle is, of course, the latter.

We are, in general, unaccustomed to viewing each menstrual period as a sign of failure of the reproductive system. Yet, that is exactly what it is to one in every five or six couples, or 15 to 20 percent of the married, reproductive age population who are infertile, defined as a failure to conceive for greater than one year without contraception.

That amounts to millions and millions of American couples involuntarily denied their fundamental biologic right of procreation and to have a family.

The frequency of infertility appears to be increasing, and for various reasons.

Contraceptives, like the intrauterine device, can cause tubal blockage.

An increased frequency of sexually-transmitted diseases also may block tubes.

There is an increase in the absolute number of people of reproductive age. More of them are seeking infertility care as social stigmatization of infertility is diminishing.

Reproductive toxins are also widely found, such as cigarette smoking, alcohol, drug use and environmental toxins.

And finally, a delay in childbearing as alluded to by Mr. Morrison decreases fecundity, that is, the natural, the monthly probability of conception. In the human, this monthly probability of conception is already quite low, about 25 to 30 percent per cycle, compared to most animal species with greater than 90 percent. It decreases significantly with age. Legitimate social and professional goals of women, along with effective contraception, delay childbearing but may have an unexpected, unwelcome cost to their fertility.

The health professionals entrusted with the care of infertile couples provide support, not just technology, for infertility is indeed a true life crisis.

First, there is often surprise, quote, "how ironic it was for me to practice birth control for years and now be infertile all along." Then there's denial, there's isolation, quote, "I can't go anywhere near my pregnant friends, anywhere near baby showers, or anywhere near my mother-in-law's probing questions." Unquote. Anger, guilt, feelings of unworthiness often follow. Masculine and feminine self identities are sorely pressed with infertility, so intimately tied to sexuality and to sex itself. Depression and then grieving are often final stages in the couples' infertility crisis, and for only some, preceding a resolution.

Infertile couples unfortunately grieve alone, for society does not recognize or support grieving the death of a dream or of a potential life, only that of an actual life.

Therefore, even couples' grief, since felt alone and without support, is unrewarding.

That is in part the human cost, the cost of unfulfilled dreams or an unfulfilled family. There are logistical and financial costs as well. For those couples who can afford it, dollars spent are just another burden to be borne at the cost of being infertile. For those who cannot afford it, they feel rather robbed of their own fundamental right to procreate, with help now being denied them simply because they are poor.

There are innumerable ways to estimate financial costs of infertility, summing up of each of the costs of the tests, summing up of each of the costs of therapy, costs it takes to achieve one pregnancy among the group of infertile couples, costs compared to adoption, insurable versus noninsurable costs, etc., etc.

The average infertility workup may be completed in four to six months at an average cost of twenty five hundred to four thousand dollars. However, the range is much, much wider.

For a $50 semen count may clearly reveal a diagnosis, or the diagnosis may remain obscure after several thousand dollars worth of evaluation.

Similarly, the cost of therapy varies widely. Therapy can be successful for $20 worth of ovulation stimulant for one month or require several surgeries of several thousand dollars each.

In vitro fertilization costs average about $3,500 to $4,500 per cycle and may require just one or if not successful, 2, 3 or more cycles to succeed.

As Dr. Hodgen mentioned, monthly probability of success approaches that of normal reproduction.

Costs of standard tests used to evaluate infertility are attached as an appendix and the reference by Cooper, 1982, is recommended.

Currently, the Office of Technology Assessment of Congress is making a major effort in compiling current statistics and costs about infertility, infertility services, and importantly, evaluating ways to prevent infertility.

A diagnosis can be established in approximately 85 to 90 percent of couples undergoing infertility investigation. The remaining 10 to 15 percent of couples thus have quote "infertility of unknown origin" unquote. i.e., where no cause or diagnosis can be assigned, and where diagnostic sophistication still needs to be improved.

Of these 85 to 90 percent of couples in whom we can make a diagnosis, male factor, i.e., infertility based on sperm number or motion, accounts for about 35 to 40 percent. Female factors account for another 40 percent of this infertility, divided between factors in the female which may influence the ability to ovulate, tube function, cervix, uterus, immunologic incompatibility, as well as a common disorder referred to as endometriosis.

The remaining 25 percent of couples in whom a diagnosis can be established have a combination of factors, multifactorial infertility, causing their difficulties in conceiving.

Many new procedures and new drugs have expanded the number of couples whom we can treat successfully to over 50 percent of those who come for care. Importantly, even before employing alternate reproductive technology. Of the others, some may conceive spontaneously over time, most never.

The new reproductive technologies now hold untold promise in capabilities for therapy in patients who had previously been unsuccessful at conceiving with more standard treatment. Estimates of the percentage of patients who may benefit from IVF who were previously not treatable, range from 80 percent of patients with tubal factor and an even astounding 25 percent of patients with infertility of unknown origin. Endometriosis, male factor, immunologic infertility, are also treated by the new reproductive technologies after other methods have failed.

Solomon was wise in his deliberations. May we all combine to have his strength and wisdom in giving guidance and counsel to the many issues that surround these technologies in striving for an important, common goal, allowing more and more couples to fulfill their dreams and rights to have children and to have a family. A right and a dream so many of us take for granted.

It is a privilege to take part in the care of these couples as it is a privilege to present this summary to you. I welcome your questions and comments and reiterate Dr. Hodgen's request for a national comprehensive deliberative process such as the Institutional Review Board of NIH, the Ethics Advisory Board, similar to that put forth by England in the Warner Commission or Australia, the Waller Commission, composed of scientists, lawmakers, ethicists and the public to formulate public policy and urge that it be done.

Thank you.

[Prepared statement of Robert J. Stillman, M.D., follows:]

PREPARED STATEMENT OF ROBERT J. STILLMAN, M.D., ASSOCIATE PROFESSOR, OBSTETRICS AND GYNECOLOGY, DIRECTOR, REPRODUCTIVE ENDOCRINOLOGY AND FERTILITY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, WASHINGTON, DC

Mr. Chairman, Members of the Committee,

I have been asked to summarize definitions, statistics, and the human and financial costs of infertility as a background to deliberations of your Committee on the new "alternate" reproductive technologies. I will try to do this in the time allotted.

The monthly cycle in women of reproductive age is comprised of a delicate, balanced, and orchestrated series of events leading to **ovulation** (passing of a mature egg from the ovary), the transport of millions of sperm through the female reproductive tract, **fertilization** in vivo, i.e., "in life," (as opposed to in vitro, i.e., "under glass"), and **implantation** of the early dividing embryo into the wall of the uterus.

If pregnancy is not achieved, the body signals the end of this reproductive cycle, and the commencement of another with **menstruation**, or the shedding of the uterine lining. The stage is set for a repetition of the orchestration with its critical biologic aim: reproduction. Indeed, there are two main, basic biologic laws applying to all species and espoused by Darwin-- 1) that of preservation of the self, and 2) preservation of the species. The biologic purpose of the reproductive cycle is, of course, the latter.

We are, in general, unaccustomed to viewing the menstrual period as a sign of failure of the reproductive system. Yet that is what it is to **one in every five or six couples, or 15 to 20% of the married, reproductive-age population who are infertile, defined as a failure to conceive for greater than one year without contraception.** That amounts to millions and millions of American couples (voters and consumers) involuntarily denied the fundamental biologic right of procreation and to have a family.

The **frequency of infertility** appears to be increasing, and for various reasons:

1. **Contraceptives**, like the intrauterine device, can cause tubal blockage;
2. An increased frequency of **sexually-transmitted diseases** also may block tubes;
3. An increase in the **absolute number of people** of reproductive age. More of them are seeking infertility care, as social stigmatization of infertility is diminishing;
4. **Reproductive toxins** are widely found, such as cigarette smoking, alcohol, drug use, and environmental toxins;
5. **A delay in childbearing decreases fecundity (the monthly probability of conception).** In the human, this monthly probability is quite low (25-30% per cycle--compared to most animals, 90% per cycle), and decreases significantly with age. Legitimate social and professional goals of women,

along with effective contraception, delay childbearing but may have an unexpected and unwelcome cost to fertility.

The health professionals entrusted with the care of infertile couples provide support--not just technologies, for infertility is a true life crisis. First, there is often **Surprise**: "How ironic it was to practice birth control for years and to have been infertile all along." Then **Denial**, **Isolation** "I can't go near my pregnant friends, baby showers, and my mother-in-law." **Anger**, **Guilt**, and **Feelings of Unworthiness** often follow. Masculine and feminine self identities are sorely pressed with infertility, so intimately tied to sexuality and to sex itself. **Depression**, and then **Grieving** often are final stages in the couples' infertility crisis--for some, preceding a **Resolution**.

Infertile couples, unfortunately, grieve alone, for society does not recognize or support grieving for a potential life, not an actual life. Therefore, even the couples' grief, since felt alone and without support, is unrewarding.

That is in part the human cost, the cost of unfulfilled dreams. There are logistical and financial costs as well. For those couples who can afford it, dollars spent are just another burden to be borne at the "cost" of being infertile. For those who cannot afford it, they feel further robbed of their own fundamental right to procreate, with help now being denied them simply because they are poor.

There are innumerable ways to estimate financial costs of infertility--summing cost of each tests or the cost of each therapy; cost it takes to achieve one pregnancy among a group of infertile couples; cost compared to adoption; insurable vs. non-insurable costs, etc., etc. **The "average" infertility work-up may be completed in from 4-6 months, at an average cost of $2500-$4000.** However, the range is much wider--for a $50 semen count might clearly reveal a diagnosis, or the diagnosis may remain obscure even after several thousands of dollars of evaluation. Similarly, the cost of therapy varies widely. Therapy can be successful for $20 worth of an ovulation stimulant for one month, or require several surgeries of several thousands of dollars each. In vitro fertilization (IVF) costs average $3500-4500 per cycle and may require 1, 2, 3, or more cycles to succeed. Costs of "Standard" tests used to evaluate infertility are attached as an **Appendix**, and the **Reference** by Cooper, 1982, is recommended. Currently, the Office of Technology Assessment of Congress is making a major effort in compiling current statistics and costs about infertility and infertility services.

A diagnosis can be established in approximately 85-90% of couples undergoing an infertility investigation. The remaining ten to 15% of infertile couples thus have **"infertility of unknown origin,"** i.e., where no cause or diagnosis can be assigned and where diagnostic sophistication still needs to improve. Of the

85-90% of couples in whom we can make a diagnosis, **male factor i.e., infertility based on the sperm number or motion, accounts for about 35 to 40%. Female factors account for about 40% of infertility.** These female factors are divided between factors which may influence the ability to ovulate, tubal function, cervical, uterine, or immunologic factors, as well as a common disorder called endometriosis. **The remaining couples in whom a diagnosis can be established (≈25%) have a combination of factors ("multifactorial") causing their infertility.**

Many new procedures and new drugs, have expanded the number of couples whom we can treat successfully to over 50% of those who come for care, even before employing "alternate reproductive technology." Of the others, some may conceive spontaneously over time, others never. The new reproductive technologies now hold untold promise and capabilities for therapy for the patients who had previously been unsuccessful at conceiving with more standard therapies. Estimates of the percentage of patients who may benefit from IVF who were previously not treatable range from 80% of patients with tubal factor infertility, to over 25% of patients with infertility of unknown origin. Endometriosis, male factor, and immunologic infertility are also treated by the new technologies after other methods have failed.

May we all combine to have the strength and wisdom of a Solomon in giving guidance and counsel in many issues that surround these technologies in striving for a common goal--allowing more and more couples today to fulfill their dreams of having a family--a dream so many of us take for granted. It is a privilege to take part in the care of these couples, as it is a privilege to present this summary to you. I welcome your questions or comments. Thank you.

Robert J. Stillman, M.D.
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May 21, 1987

APPENDIX.

COSTS OF TESTING AND PROCEDURES FOR INFERTILITY EVALUATION

1. **Consultation**, $100 for evaluation and review of records, support, and discussion of the plan.

2. **Testing** examines each component of **normal reproduction** to see which might be leading to infertility:

   a. **Ovulatory factors:**

      1. temperature charts,
      2. urine hormone kits ($50 per cycle),
      3. hormone studies (approximately $50 apiece),
      4. endometrial biopsy ($250).

   b. **Male factor** is evaluated:

      1. semen analysis ($50),
      2. sperm penetrating assay ($250),
      3. hormone studies (approximately $200),
      4. immunologic studies (to evaluate incompatibility between the male and the female) ($250).

   c. The **uterus and the tubes** are evaluated (for their ability to conduct the sperm and egg function), ($325).

   d. **Cervical mucus production (post-coital test)** ($75),

   e. **Laparoscopy/evaluation of the pelvic tubes and ovaries** in a minor operative procedure), (total cost between $2000 and $5000.

It is important to understand that not all tests need to be done on all patients; sometimes, evaluation is reasonably straightforward and simple. Other times, tests need to be repeated or further testing beyond those listed above, needs to be done in special circumstances. It should be noted that through the Office of Technology Assessment, the Congress is making a major effort at developing cost/use analyses of infertility services with the help of infertility specialists nation-wide.

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STATEMENT OF WENDY CHAVKIN, M.D., DIRECTOR, BUREAU OF MATERNITY SERVICES AND FAMILY PLANNING, NEW YORK CITY DEPARTMENT OF HEALTH, NEW YORK, NY

Dr. CHAVKIN. Thank you for the opportunity to speak today.

I am starting from the presumption that our policy goals are twofold: that all Americans should be able to make choices about reproduction and that we seek to promote social justice.

The new reproductive technologies offer mechanisms for achieving one objective toward the goal of reproductive choice. Attainment of the goal, however, requires that we place these new reproductive technologies in context and the relevant context I would suggest is that of a nation whose citizens too often lack access to basic reproductive health care services.

Rates for both infant and maternal mortality in the United States lag far behind those of other developed nations. Black infants continue to die at nearly twice the rate of white infants and black women die in association with pregnancy at more than twice the rate of white women. Such racial disparities have persisted and, in fact, recently widened for these and other adverse reproductive parameters. It appears that the United States will not meet the Surgeon General's 1990 goals for infant and maternal mortality.

Because there is no national entitlement program for perinatal health care services, many American women receive late or no prenatal care. Approximately 25 percent of American women do not obtain prenatal care in the first three months of pregnancy. Because of geographic maldistribution of health services and financial barriers, other reproductive health care services such as gynecologic care, family planning, abortion and treatment for sexually transmitted diseases, are even less accessible. For example, almost 80 percent of all counties in the United States lack any providers of abortion.

The new reproductive technologies are geared toward increasing options for the infertile, estimated to be one in six American couples. Focus on these, I would suggest, represents a search for a technologic fix to issues with social roots. I would suggest that we concentrate resources and attention on the underlying causes of infertility. Among these are:

Sexually transmitted disease epidemics and inadequate contraceptive options. Pelvic infection resulting from sexually transmitted disease and nonbarrier contraceptive methods, particularly the IUD, can lead to scarred, nonfunctioning fallopian tubes and infertility. Both of these require us to allocate resources for research, address financial barriers to health care to ensure that people receive treatment and encourage public discussion of these matters to ensure that people receive correct information.

Environmental and occupational toxic exposures that impinge on reproductive health. Lead and other heavy metals, pesticides and radiation are among those substances that have been implicated in damaging both male and female reproductive success. To tackle this requires a commitment to enforcing standards for a clean environment and clean workplaces that would protect the reproductive health of men and women and to allocating resources for further research.

Demographic trends toward delayed childbearing reflect the fact that some women are deferring childbearing until their late 30s because of workplace pressures. Infertility, miscarriage and chromosomal anomaly rates all increase with advanced maternal age. Social policy must catch up with the reality that women of childbearing age are now permanently in the American labor force. Currently, many women lose their jobs if they take off any time at all from work after delivering a baby. A parental leave policy that guarantees job security is a necessity so that women are not pushed to make unacceptable tradeoffs between work and children. Leave time to care for sick children and high quality childcare must become widely available in order to enable women and men to be parents and workers simultaneously. These policies would enable women to begin having children at earlier ages without financial sacrifice.

A second approach to addressing the problem of infertility is adoption. The questions raised by the new reproductive technologies offer us the opportunity to question some of our assumptions. Why are we taking for granted pursuit of a genetically related child in the face of so many children without parents? We could instead be rethinking our adoption and foster care systems so as to expand and expedite the opportunities for this type of family formation.

Finally, I would like to urge that any new arrangements regarding reproduction not further exacerbate social inequities. As a physician whose experience is in obstetrics and public health, I am disturbed that some appear to be viewing children as commodities and seeking to have the perfect child in the same way they might search out the best refrigerator. A vision of children as consumer products extends to women as well, who are in danger of being viewed as disembodied uteri for rent or considered essentially as breeders.

To limit these more sordid possibilities, I urge that commercial profiteering be restrained in this area. Our society already does not permit "free contract" when it comes to the sale of organs or babies, because we recognize the coercion implicit in the marketplace in a society of economic disparity. If we disallow fees for eggs, sperm, uterus use, babies and brokers, we reduce the opportunities for economic exploitation while at the same time keeping the door open for medical innovation. Moreover, we refuse to allow venture capitalists as described in last week's "New York Times" to dictate our choices for research and resource allocation in this most human arena.

Until the social and health needs I have outlined are resolved, I would suggest that despite our stated respect for the rights to bear children and to privacy, in fact material circumstances limit procreative choice for many Americans.

Thank you very much.

Mr. MORRISON. Thank you, Dr. Chavkin.

Dr. Doerflinger?

[Prepared statement of Wendy Chavkin, M.D., M.P.H., follows:]

PREPARED STATEMENT OF WENDY CHAVKIN, M.D., M.P.H., DIRECTOR, BUREAU OF MATERNITY SERVICES AND FAMILY PLANNING, NEW YORK CITY DEPARTMENT OF HEALTH*

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*For identification purposes only.

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- Sexually transmitted disease epidemics and inadequate contraceptive options. Pelvic infection resulting from sexually transmitted disease, and non-barrier contraceptive methods, particularly the IVD, can lead to scarred, non-functioning Fallopian tubes and infertility. Both of these require us to allocate resources for research, address financial barriers to health care to ensure that people receive treatment, and encourage public discussion of these matters to ensure that people receive correct information.

- Environmental and occupational toxic exposures that impinge on reproductive health. Lead and other heavy metals, pesticides and radiation are among those substances implicated in damaging male and female reproductive success. This requires a committment to enforcing standards for a clean environment and clean workplaces that protect the reproductive health of men and women, and to allocating resources for further research.

- Demographic trends toward delayed childbearing reflect the fact that some women are deferring childbearing until their late 30's or beyond because of workplace pressures. Infertility, miscarriage and chromosomal anomaly rates all increase with advanced maternal age. Social policy must catch up with the reality that women of childbearing age are now permanently in the American labor force. Currently many women lose their jobs if they take off any time at all from work after delivering a baby. A parental leave policy that guarantees job security is a necessity so that women are not pushed to make unacceptable trade-offs between work and children. Leave time to care for sick children and high quality childcare must become widely available in order to enable women and men to be parents and workers simultaneously. These policies would enable women to begin having children at earlier ages without financial sacrifice.

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Until the social and health needs I have outlined are resolved, I would suggest that despite our stated respect for the rights to bear children and to privacy, material circumstances limit procreative choice for most Americans.

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STATEMENT OF RICHARD DOERFLINGER, ASSISTANT DIRECTOR OF THE OFFICE FOR PRO-LIFE ACTIVITIES, NATIONAL CONFERENCE OF CATHOLIC BISHOPS, WASHINGTON, DC

Mr. **Doerflinger**. Thank you. The title of this hearing—"Alternative Reproductive Technologies: Implications for Children and Families"—reflects the same concerns expressed in the Vatican's recent "Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation."

This document urges that public policy regarding these technologies be guided by two key principles: the human dignity of the child, especially the child's fundamental right to life from the time of fertilization onward; and the integrity of marriage and the family.

These principles are widely recognized as proper concerns not only of specifically religious belief or private morality but also of legislation that seeks to serve the common good. For example, human rights declarations by the United Nations affirm that children need "special safeguards and care, including appropriate legal protection, before as well as after birth," and recognize the family as "the natural and fundamental group unit of society" which is "entitled to protection by society and the State." I would like to discuss each principle and then comment upon their application to federal policy on in vitro fertilization.

First, the dignity and rights of the child.

Practices which violate the life and physical integrity of the newly conceived child can range from abortion to the discarding or freezing of spare embryos produced in the laboratory, to experimental manipulation. Congress currently opposes such practices by barring Federal funding for abortion and for harmful nontherapeutic experiments on the unborn child.

In 1985 the Health Research Extension Act improved protections for the human subject in fetal experimentation and imposed a three-year moratorium on any waiver of such protections by the Secretary of HHS. A waiver would only be necessary if one wished to authorize unethical experiments—that is, those which subject an individual human being to risk of harm or death solely to gain knowledge for the benefit of others, rather than for the benefit of that individual. Hence when the moratorium expires in 1988 we will urge Congress to bar such waivers permanently.

Some groups and individuals studying the issue of experimentation on the human embryo have suggested allowing nontherapeutic experimentation until 14 days after fertilization, because of speculations about the significance of phenomena such as implantation and twinning. We share the conviction expressed last year by the Select Committee commissioned by the Australian Parliament to study this issue, that "no one event succeeding fertilization is such that it can bear the weight that some would attach to it" for the purpose of justifying harmful experiments prior to that event. The newly conceived member of the human species should be accorded the respect due to a human subject at every stage.

Second, the integrity of marriage and the family.

According to the U.S. Supreme Court, "the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition." That institution's integrity, hence its proper role in maintaining the order of society, can be eroded when relationships between husband and wife or between parent and child are blurred or redefined in some reproductive procedures. Without ignoring the needs of infertile couples, society must take care that procedures designed to help build families will not unintentionally undermine the social and legal status of the family.

Of special concern are methods which introduce outside third parties into the marriage relationship for purposes of reproduction. It is now possible for a child to have as many as five parents: the "genetic" parents or sperm and egg donors, the gestational mother, and the couple that intends to raise the child. In such arrangements the child is denied his or her right to a unified family, and the moral and legal responsibilities traditionally seen as inherent in being a biological parent are diffused and rendered problematic. Family relationships are redefined in terms of commercial contract law, risking the reduction of human beings to the status of objects. Surrogate motherhood has rightly been criticized along these lines for its tendency to exploit the biological mother as a "surrogate uterus" and to reduce the child to a commodity for sale.

Third, Federal policy on in vitro fertilization.

In 1979, an Ethics Advisory Board reported to the Secretary of HEW on the advisability of funding in vitro fertilization projects involving humans. The Board concluded that Federal support would be "acceptable from an ethical standpoint," but it refrained from recommending such support, citing "uncertain risks" to both mother and offspring, "the dangers of abuse" such as experimental manipulation of the embryo, and the fact that the procedure is "morally objectionable to many." In that regard I would differ, I think, from Dr. Hodgen, who said the panel made a definite recommendation on this matter. It cited the complexity of the issue and left the final decision to HEW's Secretary, Patricia Harris, who decided that no funding would become available for these procedures.

Citing abortifacient elements of the in vitro procedure and other factors, the U.S. Catholic Conference was among those successfully urging the Secretary not to institute such funding.

Recent developments have only heightened the concerns that led us to take this position. In vitro fertilization has become a source of embryos for unethical experimentation and has become a means for introducing additional parties into the marriage relationship. The cost in terms of human embryonic lives is enormous, with one recent international study estimating that out of 14,585 fertilizations in 62 different in vitro centers, only 4 percent resulted in a live birth. The figures in Dr. Hodgen's testimony are consistent with this. He cited a 25 to 30 percent success rate per fertilization cycle, a rate of success in achieving pregnancy. If you look at his data, the figures for live births for hundred embryos fertilized would be 4.6 percent.

Efforts to prevent or cure diseases that cause infertility represent a responsible alternative way of investing taxpayers' dollars. Especially at a time when health programs may suffer severe cuts in the drive to meet budgetary targets, our government should seek to maintain and improve access to basic health care for the poor rather than diverting funds to more spectacular but morally questionable technologies.

Finally, it is our view that much of the demand for exotic reproductive technologies is due to the fact that many infertile couples see adoption as difficult or impossible. This was certainly a factor in the well-known Baby M Case, for the Sterns had considered adoption first. The Federal government is not doing nearly as much as it can and should to remove obstacles to adoption. Adoption does not divide or redefine families but copes with the reality of non-existent or non-functioning families in such a way as to benefit everyone: the child, birth parents, and the adoptive couple.

Yet the only Federal program facilitating adoption for unmarried pregnant teenagers, for example, the Adolescent Family Life Program, has never received adequate funding and now risks being phased out altogether; a Federal tax deduction for the expenses of special-needs adoption was eliminated by the 1986 Tax Reform Law after being in existence only five years. These and other avenues deserve renewed consideration as means for helping children, infertile couples and society as a whole. Thank you.

[Prepared statement of Richard Doerflinger follows:]

PREPARED STATEMENT OF RICHARD DOERFLINGER, ASSISTANT DIRECTOR OF THE OFFICE FOR PRO-LIFE ACTIVITIES OF THE NATIONAL CONFERENCE OF CATHOLIC BISHOPS, WASHINGTON, DC

I am Richard Doerflinger, Assistant Director of the Office for Pro-Life Activities of the National Conference of Catholic Bishops.

The title of this hearing--"Alternative Reproductive Technologies: Implications for Children and Families"--reflects the same concerns expressed in the Vatican's recent Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation. This document urges that public policy regarding these technologies be guided by two key principles: the human dignity of the child, especially the child's fundamental right to life from the time of fertilization onward; and the integrity of marriage and the family. These principles are widely recognized as proper concerns not only of specifically religious belief or private morality but also of legislation that seeks to serve the common good. For example, human rights declarations by the United Nations affirm that children need "special safeguards and care, including appropriate legal protection, before as well as after birth,"[1] and recognize the family as "the natural and fundamental group unit of society" which is "entitled to protection by society and the State."[2] I would like to discuss each principle in turn, then comment on federal policy regarding in vitro fertilization.

1. The Dignity and Rights of the Child at Every Stage of Existence

Practices which violate the life and physical integrity of the newly conceived child can range from abortion, to the discarding or freezing of "spare" embryos produced in the laboratory, to experimental manipulation. Congress currently opposes such practices by barring federal funding for abortion and for harmful non-therapeutic experiments on the unborn child. In 1985 the Health Research Extension Act improved protections for the human subject in fetal experimentation and imposed a three-year moratorium on any waiver of such protections by the Secretary of HHS.[3] A waiver would only be necessary if one wished to authorize unethical experiments--those which subject an individual human being to risk of harm or death solely to gain knowledge for the benefit of others. Hence when the moratorium expires in 1988 we will urge Congress to bar such waivers permanently.

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According to the U.S. Supreme Court, "the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition."[5] That institution's integrity, hence its proper role in maintaining the order of society, can be eroded when relationships between husband and wife or between parent and child are blurred or redefined in some reproductive procedures. Without ignoring the needs of infertile couples, society must take care that procedures designed to help build families will not unintentionally undermine the social and legal status of the family.

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NOTES

[1] Declaration of the Rights of the Child (1959), Preamble.

[2] Universal Declaration of Human Rights (1948), Article 16.

[3] Public Law 99-158; 42 U.S.C. §289g.

[4] Senate Select Committee on the Human Embryo Experimentation Bill 1985, Human Embryo Experimentation in Australia (Australian Government Publishing Service, Canberra 1986), p. 26 (para. 3.9).

[5] Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977) (plurality).

[6] See "Report of the Ethics Advisory Board," Federal Register, June 18, 1979, pp. 35056-8.

[7] Greg Erlandson, "Vatican Concerned About High Death Rate of Embryos in Labs," National Catholic News Service, March 12, 1987 (reporting on a study presented at the Third World Congress on In Vitro Fertilization and Embryo Transfer held in Helsinki, Finland, in 1984). Cf. "Wide Disparity in IVF Practices," Medical Tribune, September 18, 1985 (in a survey of 54 IVF clinics registered with the American Fertility Society, 52 percent of the clinics reported no live births); "Advises Telling IVF Patients Truth About Rates of Pregnancy," Ob. Gyn. News, March 1-14, 1987 (chance of a live birth from each in vitro cycle is 5-7%, and the patient should be prepared to undergo at least six treatment cycles to improve chances for success); Editorial Capsule, "The In Vitro Fertilization Pregnancy Rate," Medical Tribune, November 27, 1985 (condemning "the widespread practice of inflating the IVF pregnancy rate"); and studies cited in Human Embryo Experimentation in Australia, supra, note 4, pp. 133-5.

Mr. **Morrison**. Thank you all. Dr. Stillman, both of the other members of the panel have suggested something in this area that has been suggested more broadly about American medicine. And that is that we favor the high-tech solution to problems and we often shortchange prevention of underlying problems that might be addressed. To what extent is the focus on the high-tech and the innovative fertility promotion depriving us of the resources and the attention necessary to be more attentive to underlying causes and other forms of getting at the problem?

Dr. **Stillman**. I think I can separate your question into two. One is the resources and the other is the attention. I don't believe the attention that is given to the spectacular reproductive technology, even though it is designed to benefit a reasonably small but critical segment of our population, does anything but enhance their capabilities. The idea that resources are being put forth, other than private resources in an institution, is very different. So the spectacular nature raises the intention, but resources are not being denied because of in vitro fertilization technologies.

Mr. **Morrison**. You're saying that because these are all private funds that are going in that direction, those resources are not available to the other approaches?

Dr. **Stillman**. I'm saying that the capabilities for use in contraception, which is as Dr. Hodgen mentioned, a major offshoot and benefit to be had from reproductive technologies and their advancement. The resources regarding preconceptual care and child care are not being diverted because of in vitro fertilization technologies. I freely support and admit that those resources are too few and perhaps in many patients too late. But it is not because of in vitro fertilization technologies. Only the amount of press and sensationalism is being drawn to in vitro fertilization.

Mr. **Morrison**. And you blame that on the Press? Let me just add to that question a little bit. It seems to me that the question of whether people choose to have children through adoption versus high tech fertilization techniques is in part driven by values that are promoted in the community and the society about what an appropriate way to have a family is. And it seems to me that these, that the sensations surrounding these alternatives certainly have something to do with what people think is valued and not valued. Do you think that's really just coming from press sensationalism or is that coming from the medical profession promoting their ability to do wonderful things?

Dr. **Stillman**. I think these issues are critical to every individual, not only those who are infertile, and they raise extremely important, sensitive, moral, ethical, legal and scientific issues. So the debate is more than appropriate. The difference though is whether resources, funds, especially governmental funds, are being siphoned off other important programs in order to support these programs. The debate is valid. The utilization of funds I reject.

Mr. **Morrison**. Dr. Chavkin, you criticize the tendency toward sort of consumer shopping attitudes toward childbearing, at the same time as you talked about choice being the, being an important, one of the important principles that we're pursuing here in terms of reproductive choice of the families involved.

That being said, how would you, allowing for choice, how would you promote these prevention oriented and more broadly health-care oriented priorities that you think would be preferable to some of the investment, whether public relations investment or financial investment, in reproductive technology?

Dr. CHAVKIN. Well, there, I definitely do see a Federal role. And that is one that has to do with allocation of resources for basic health care needs. I mean, today we're talking particularly about those health care needs related to reproduction. But as we all know very well, financial barriers keep many people in the United States from getting the health care which they need.

Mr. MORRISON. Mr. Doerflinger, you criticized a circumstance in which a child would be the product of more than two parents, somehow suggesting that that threatened the integrity of the family.

I don't understand how that is any more a problem than the problem of an adopted child having different biological parents from the parents by whom he or she is raised. Why is that a problem? Where do you distinguish the two?

Mr. DOERFLINGER. Well, I think the distinction would be that adoption moves into a situation where there is no functioning family, and makes the best of a bad situation by bringing the child into a unified, loving family, husband and wife.

In the case of these technologies and arrangements like surrogate motherhood, which I don't like to call a technology because the technology involved is 200 years old, but in some of these new reproductive arrangements, we are talking about deliberately, for example, having a woman conceive a child for the purpose of abandoning it, some would say selling it, to others. We are intentionally dividing up the family and redefining it.

Mr. MORRISON. But isn't it the case that, I mean you talked in terms of the problem of a child having all these parents. Leaving aside the earlier choices, isn't the child in exactly the same circumstance? If there is a problem at all—I happen to be adopted myself, so I speak with some experience on this question—isn't it the same circumstance, the separation of biological parenthood from nurturing parenthood, isn't that the same? Isn't that a false issue that you're raising? I think there are ethical issues about the initial choices, but it would seem to me they're only clouded by your trying to suggest that having different biological parentage is an insurmountable barrier.

Mr. DOERFLINGER. I didn't say anything about an insurmountable barrier, sir. The analogy would be if you were to create a Federal program for deliberately conceiving children in circumstances where you know someone will have to give them up for adoption. Then you would be making the dividing of the family part of your intent.

Mr. MORRISON. Both of you said we weren't funding adequately the one that people don't have an abortion but have the child and give them up for adoption? Isn't that the same thing?

Mr. DOERFLINGER. I don't think that restrictions on abortion funding force people to conceive anybody, sir.

Mr. MORRISON. No, I mean the point is you just criticized the notion of somebody having a child and giving it up for adoption. In fact, one of the programs that you recommended is one to encourage teenagers who are pregnant to go, to carry the child to term and give it up for adoption in preference to having an abortion?

Mr. **Doerflinger**. The Adolescent Family Life Program deals with services of health care, vocational assistance and adoption assistance to teenagers who are already pregnant. In other words, this is their situation. There is no husband, there is no stable relationship. And we have a situation in which we are trying to help to do the best for the child and the mother and for an adoptive couple. As I say, it's coping and doing the best in a bad situation. To set up those situations deliberately would be a different matter.

Mr. **Morrison**. The gentleman from Indiana.

Mr. **Coats**. I think you all heard Dr. Hodgen's testimony about the desirability of reconstituting this Ethics Board through NIH. I would like to get your three reactions to that and what potential problems we might be looking at if we proceeded down that road.

Dr. **Stillman**. As I mentioned, Mr. Coats, at the end of my remarks, I fully support the reinstitution of the Ethics Advisory Board and I think it's important, even though the name is Ethics, it's Advisory and it's a Board that is reporting to the DHHS Secretary, and they are not a legislative body, they are not anything but an important deliberative body, to bring together a wide variety of individuals, scientists, ethicists and the public, all divergent views, to formulate some sort of national policy by which other states and the Federal government might take advice, might take advice, and utilize in their deliberations.

Mr. **Coats**. Dr. Chavkin.

Dr. **Chavkin**. I would also support that. I think this area, as people have touched on already this morning, is so fraught with complicated issues that we really need to be probing into very deeply. One example of a dilemma that I can suggest right now is whether or not we move to have Medicaid funding extended to some of these procedures. I'm of two minds about it personally because on the one hand, I think that without that, it becomes an option only to those who have the financial means to pursue it, and I think that kind of inequality is not something I would support. On the other hand, by providing Federal funding, are we giving a green flag and perhaps diverting our limited health dollars?

Mr. **Coats**. Mr. Doerflinger.

Mr. **Doerflinger**. As I mentioned in my testimony, I think the Ethics Advisory Board of 1979 did a good job of uncovering some of the complexity of the issue. When they judged in vitro fertilization to be ethically acceptable, they defined that phrase to mean "ethically defensible but still legitimately controverted." And I think that remains true. If the purpose of re-establishment of an Ethics Advisory Board would be to begin approval of experiments involving in vitro fertilization, I'd be against that. I think the problems raised by the Ethics Advisory Board and the possible abuses they foresaw have all proved true.

If the purpose were to continue to study the ethical, legal, and political issues of these technologies, I would just like to point out that there are already two bodies doing just that. One is a panel of the Office of Technology Assessment, which is going to be publishing a very lengthy report on this next year with the aid of an advisory panel of approximately 20 experts. The other is the Congressional Biomedical Ethics Board, which was established by the same legislation that improved protections in fetal experimentation back in 1985. And some of the members of that Board, I believe, are very interested in studying these issues.

Dr. **Stillman.** We as a nation are way behind Australia and England in putting together, formulating suggestive policy from a national review committee. The Warner Commission in England and Waller Commission in Australia have done a great deal of benefit, and there is a diversity of opinion of that benefit, but a great deal of benefit in allowing debate and public policy to come to fruition and come to the public's eye. And that is really what the Ethics Review Board is designed to do in this country.

The 1979 report was 1979, one year after the first birth of an in vitro fertilization baby, and a lot has happened in improving techniques and changing techniques since that time. That review board has not met, of course, it has been disbanded and needs to be updated and brought to the United States, up to snuff on this issue.

Mr. **Coats.** Mr. Doerflinger, I wonder if you could describe some of your concerns about the fetal research. Obviously, there are two sides to this. Some of it can, if it's therapeutic for the child, can be very beneficial. But describe the nature of some of the fetal research and particularly those areas that you have concerns in.

Mr. **Doerflinger.** All right. The principles I'm working from are principles that were established by the World Medical Association in its Declaration of Helsinki. The key principle here is that the human subject should never be treated just as a means to knowledge that can benefit others. And this is particularly true of someone who is incapable of consenting freely to such experimentation, which would include all children. The present standards for fetal experimentation came to light out of a long process beginning in 1973, when some particularly grisly experiments came to light involving the decapitation and experimentation on children who were born alive during late term abortion. And Congress quite rightly reacted with revulsion to this and put a moratorium on all such experimentation until new regulations would be written.

The regulations that were written had certain loopholes in them. Under one of those loopholes, for example, women who were intending to have elective abortions were singled out to have rubella vaccine tried out on their children so that it could be found out whether the vaccine caused birth defects or not, whether it harmed the children. Of course, it did. The standards have now been improved to the point where the child who someone may intend to abort can't be singled out as a guinea pig for particularly harmful experiments like this. I think the standards that are in place now for fetal experimentation are quite good and should be made permanent. The problem is that fetal experimentation, as I just defined it, starts with implantation. There is a separate policy, a more informal policy on in vitro fertilization and embryo research, which at this point is a total ban. And the kinds of experimentation that are possible in the early embryonic stage run the full gamut from the kinds of research Dr. Hodgen was talking about regarding testing all the different possibilities for fertilization, presumably with later discarding of the embryos used in the research, all the way to different kinds of genetic experiments, even human-animal hybrids. The danger to the subject here is of a more fundamental character than any other kind of research that we may think of, because we're talking about a risk of actually depriving someone of membership in the human species, which is something we haven't made possible before this time.

Mr. **Coats**. Do you think the guidelines that have been put in place subsequent to some of these earlier disclosures are adequate?

Mr. **Doerflinger**. The fetal experimentation statutes or improvements were enacted in 1985, are adequate regarding protection of the child——

Mr. **Coats**. Nothing has happened since that 1985 Act that would require that that law be amended or updated?

Mr. **Doerflinger**. No, but there is one aspect of the 1985 law, the waiver clause I was talking about in my testimony, which is a temporary moratorium. The expectation is that the Congressional Biomedical Ethics Board will be reporting back to Congress with recommendations on whether to make the prohibition of the waiver permanent or whether to reinstitute it in some limited form.

Mr. **Morrison**. The gentleman from Georgia.

Mr. **Rowland**. Thank you, Mr. Chairman. You mentioned the Biomedical Ethics Board. I wonder whether the other two members of the panel are familiar with that, too. The Biomedical Ethics Board?

Dr. **Stillman**. Not familiar with it.

Mr. **Rowland**. Not familiar with that? Well, it was a board that was created I believe last Congress with members from the House and Senate which would select a committee of experts from around the country and I just wondered if you, you said you wanted the Ethics Committee reconstituted. I didn't know whether you were aware of the Biomedical Ethics Board or not. It was created to take the place of the Ethics Committee, as I understand it.

Dr. **Stillman**. Well, the comment about the Office of Technology Assessment and its being a deliberative board is, I believe from its function, and there are people here from OTA, it's really a fact gathering, regarding financial and resources and not necessarily in any way means to be an ethical or moral deliberative body.

Mr. **Rowland**. Exactly. Well, OTA helped us screen some applicants for the committee for the Biomedical Ethics Board and I just wanted to bring that to your attention.

Let me be sure I understand why you are opposed to surrogate motherhood. I don't have a position on that right now, but I'd just like to know why you are opposed to it.

Mr. **Doerflinger**. I think the first objection would be in terms of deliberately going outside a marriage relationship to reproduce. Some people have said, only half-jokingly, that Mr. Stern was not hiring a surrogate mother, because Mrs. Whitehead was in every sense the biological mother, both the genetic and gestational mother of the child. What he was hiring in a sense was a surrogate wife. What is meant by that is that one ordinarily expects that when people consent to marriage, one of the things they are consenting to is that they will have children only by each other. Now, that's broken down in this. We've already got a division between marriage as a union of love and marriage as a reproductive institution. The child then is denied from the outset the attention of both biological parents. And as I was emphasizing earlier, this is an intentional and deliberate part of the procedure, it's what you set out to do. The other objections that have been raised, particularly regarding commercial surrogacy, involve analogies to slavery, because of the implication that a woman's body has been rented for the purpose of reproducing, and the implication that a child is being sold.

In our adoption laws, we have been fighting abuses by forbidding specifically this sort of thing, the direct exchange of money for a child. And there are safeguards against that. In the Baby M decision that Judge Sorkow gave in the trial court in New Jersey, he claimed for a number of reasons that this is not baby selling. For example, he said that what was being exchanged for money here was the use of Mrs. Whitehead's body for reproductive services and not the selling of the child. In fact, if you look at the contract, the $10,000 fee is dependent upon delivery of a live child to the Sterns. If the child were miscarried or stillborn, Mrs. Whitehead would only have gotten $1,000. The other $9,000 is the sale fee for a child. The implications here for the dehumanizing of all the parties concerned are very grave. And we think that this is something that is not good public policy to promote or encourage or to allow.

Mr. Rowland. Would you be opposed to it if there was no fee charged?

Mr. Doerflinger. I think the commercial aspect of the fee makes the problem worse. But I think the first considerations I raised would still be the same. And the thing that is integral to a surrogate motherhood contract is the fact that unlike certain kinds of private activities that may be immoral but which the law may not want to reach, may want to step back from, the drawing up of a surrogate motherhood contract inevitably involves the state in the enforcement of the contract. So whether commercialism is involved or not, if you're going to have a contract that has the force of law, the state is already involved in allowing and indeed promoting this kind of procedure. Some of the problems still remain.

Mr. Rowland. I was interested in Mr. Morrison's comments about adoption and why you would not be opposed to adoption but would be opposed to this. Did I hear you say that you felt that a child, or maybe you inferred this, would be less loved by the parent who was not the biological parent in surrogate motherhood?

Mr. Doerflinger. No, I think the problem in the Baby M Case has been that everybody loves somebody all too much, rather, that both sets of parents love the child.

Mr. Rowland. Wouldn't you have the same problem in adoption? That everybody would love the child?

Mr. Doerflinger. Again, in adoption I think the difference is that you have a position in which the child was conceived in a situation where the mother cannot provide the love and attention and nurturing that the child needs. The mother voluntarily decides to go through an adoption plan so that the child can have a loving family. There can be complications, there can be a great deal of grief involved, but at least the mother knows that the best is being done for the child and that she is helping this other couple. The possibility of the mother changing her mind is also always accounted for because an adoption plan cannot be ratified until the mother repeats her decision to give up her parental rights after the time of birth. This is another thing that most surrogate motherhood contracts don't allow.

There are, I think, many differences between the two.

Mr. **Morrison**. I'd just like, if I could, to clarify what you said about, you're talking about the enforceability of a contract. Are you drawing a distinction between whether the state outlaws surrogate parenthood or whether it enforces a, let's say there's a contract with no financial consideration, just an agreement with certain stipulations, no financial benefit at all. There is a distinction between the enforceability of that contract and statutory prohibition of the conduct. Are you seeking to draw that distinction by saying there's something you might consider immoral that the State wouldn't reach or not?

Do you understand the distinction I'm drawing?

Mr. **Doerflinger**. I drew a distinction between a law that would simply say such contracts are unenforceable and a law that would say the practice is prohibited.

Mr. **Morrison**. Are you advocating one position or another to us?

Mr. **Doerflinger**. At this point, the surrogate motherhood issue has been largely a matter of state law and in that sense, positions on specific legislation have been taken by State Catholic Conferences. So I don't have a piece of model legislation——

Mr. **Morrison**. Do you have a position, without deciding for us whether this is a matter of State or Federal law, do you have a position? Do you think there is a difference that we ought to recognize between enforceability of contracts or prohibition of conduct on this question?

Mr. **Doerflinger**. I think obviously it's a distinction that has to be recognized. I'm trying not to go beyond my mandate here, because the National Conference of Bishops doesn't take positions on specific state legislation.

Mr. **Morrison**. I see. Okay. I think some other people on the panel wanted to comment on that. I apologize to my colleagues, but I think that getting this clear would help. Go ahead.

Dr. **Chavkin**. I appreciate your distinction and I would have different positions personally according to the lines you drew.

I would be reluctant to see a prohibition, because of concerns about governmental intrusion into certain private matters, although I would be interested in exploring a prohibition against the profiteering aspect. At the same time, I would be interested in also exploring seeing that contract as a nonenforceable one and using the analogy to adoption where the gestational mother maintains the ability to change her mind for a given period of time after the birth.

Mr. **Morrison**. Dr. Stillman?

Dr. **Stillman**. I think the difference is a critical one and that Federal and State interference in the procreative right and privacy right of drawing up the contract including whether it contains fees to be paid is in my view and in many others, inappropriate. The idea that the state at whatever level of jurisdiction would not seek to enforce the contracts that have been drawn up in privacy is a matter for that jurisdiction and one of appropriate debate.

Mr. **Morrison**. The gentleman from Illinois.

Mr. **Hastert**. Thank you, Mr. Chairman.

Dr. Stillman, Dr. Hodgen was answering some questions and we were interrupted. One of the things that he started to talk about was the importance of the Ethics Advisory Board to decide on what type of experimentation was ethical and what was not ethical using the terms or the parameters of whoever describes what ethical is.

The makeup of this Board is basically as you understand what? Other doctors, or——

Dr. **Stillman**. Oh, no; it's a wide range of ethicists, legal experts, public as well as researchers and scientists.

Mr. **Hastert**. Lawyers, doctors?

Dr. **Stillman**. It's a critical aspect of that nature.

Mr. **Hastert**. One of the things that we started to talk about and he was talking about is that in the value of in vitro fertilization in the study of other types of—well, the study of sperms and eggs actually coming together and the best way to prevent that and that whole area of scientific study.

Is there an issue, would this Board then decide when that experimentation, you take an egg and a sperm and you put it in this dish and watch what happens and experiment on it? Do they decide when that sperm and egg becomes an embryo or not? Is that the role of this Board?

Dr. **Stillman**. I don't believe so.

Mr. **Hastert**. What is it, then?

Dr. **Stillman**. It's to bring to bear the idea of divergent group opinions of experts with different opinions to suggest to policymakers and legislators the results of a deliberative process.

Mr. **Hastert**. But this Board becomes more or less of a turnstile in a gate whether that type of experimentation takes place.

Dr. **Stillman**. To be sure. If the legislators or public in a jurisdiction want to have it function as the turnstile, without their own added deliberation, then certainly they're free to do so. An example would be what is a standard of care and what becomes ethical standard of care. Almost all physicians who are doing in vitro fertilization fully ascribe to the ethical stance of the American Fertility Society. That's purely voluntary that they do so.

Mr. **Hastert**. That's done on a local level, then, in the State of New York it would be one standard and the State of Ohio it could be another standard?

Dr. **Stillman**. Indeed, and that's one of the ideas that a national deliberative process would try and minimize. Obviously there are differences from jurisdiction to jurisdiction.

Mr. **Hastert**. And the National Ethics Advisory Board would actually be a national turnstile of what's right and what's wrong; is that correct?

Dr. **Stillman**. Of what they suggest may have major ethical consequences and what might by the deliberation——

Mr. **Hastert**. So actually we have a board of people who are quote unquote "experts," which I'm sure they would be in their own respective fields, and they're actually making moral decisions from a wide spectrum—even at this table we have quite a divergent view of what's right and what's wrong, what's moral and what's immoral—but somebody in the place of the legislator, in the place, would be making those decisions on whether this in vitro fertilization, as a case of an experiment and not as a case of bringing in a substitute mother or being able to provide children to somebody who can't have children, but actually for the purpose of experimentation, it would be their decision whether this should take place or should not take place; is that correct?

Dr. **Stillman**. Not correct.

Mr. **Hastert**. I've lost you someplace, then.

Dr. **Stillman**. Well, then, if we can go through it. Perhaps in a jurisdiction in Wyoming if a particular situation at a medical center was in debate and the legislature was considering whether or not appropriate laws were appropriate to bring forth, they might utilize the national deliberative process with its diversity to help them, including the experts that were on the board, or others, to help them reach conclusions that they felt for their jurisdiction, State, local or otherwise.

Mr. **Hastert**. Let's say the State chooses not to take that up. I've been in legislature, too, and sometimes that type of legislation comes up and it doesn't get passed or people don't debate it and there's somebody who wants to do this and in absence of law, these people pretty much determine what's right and wrong.

Dr. **Stillman**. De facto, perhaps. They're certainly not making legislation.

Mr. **Hastert**. Exactly.

Dr. **Stillman**. That would be up to the legislators in Wyoming to decide whether they wanted somebody else——

Mr. **Hastert**. Or in the place of a vacuum of such legislation that's legally described they would be the deciders of morality in a sense.

Dr. **Stillman**. As is case law.

Mr. **Hastert**. Thank you.

Dr. Chavkin, you made a statement that was interesting to me and I would like you just to define a little bit more. You said this is really a two-pronged issue—one of medical technology and another of social justice. How do you define especially the social—I understand medical technology. What social justice are you talking about?

Dr. **Chavkin**. Well, I was talking about the fact that so many Americans lack access to basic health care services that would in fact translate this abstract right to have a family into a concrete, real ability to make those kinds of decisions because they would have the health care that is necessary in order for them to further those plans.

Mr. **Hastert**. All right, and then you said that you—let me carry that one step farther—you were concerned that in doing this you may divert funds from traditional health care, too; is that correct?

Dr. **Chavkin**. In pursuing some of these new——

Mr. **Hastert**. You said you had mixed emotions about that.

Dr. **Chavkin**. I do have mixed emotions because I am a physician and I do have respect for the wonders that are brought to us by medical technology and further development. So it is hard for me to in any way suggest foreclosing that. At the same time, I'm now a public health physician and I am every day aware of the fact that in this country people are not getting the most basic services. In the city in which I come from a significant proportion of women do not receive prenatal care and our infant mortality rate—and this is true nationally—just bears no relationship to our technological prowess. So that is what I was trying to direct attention toward.

Mr. **Hastert**. I appreciate that. One of the things that you also brought out is that people are, women today are making choices, are making choices to prolong their career and pushing the age, having children at 35, or in an area where it's questionable that they can have healthy children. So this gives them alternatives to those choices? Once they've made their choice, it gives them another alternative; is that correct?

Dr. **Chavkin**. It is. I was suggesting that there might be other alternatives that would enable them to make other choices as well, and specifically if there were policies—parental leave is the one that comes to mind most immediately—but if there were policies that acknowledge that women are in the labor force in their childbearing years, and that enabled them to carry out both aspects of parenting and working simultaneously, they might not then find themselves at age 38 pursuing some technological——

Mr. **Hastert**. And also, and I try to take this out of a moral light one way or another, because it's hard to examine some of these things in a scientific way when you're looking at two sides of a moral argument. It also gives people who choose not to become part of this family because of function, because of maybe their career choices, at age 37 or 38 they want to have children and they want to remain single, they have the option to do that?

Dr. **Chavkin**. Right.

Mr. **Hastert**. Thank you. Mr. Doerflinger, this issue of course, when you start to focus on it, some of the questions that I asked Dr. Stillman about moral choices and decisions—how do you view that? What do you see? Do you see that as a threat to your movement, Pro-Life movement, when we have a board that actually makes moral policy that says that these experimentations, and some of them are experimentations not for the purpose of having, providing children to childless families but actually for the sake of experimentation—do you see that as a threat to the integrity of this nation somehow?

Mr. **Doerflinger**. I'd like to make a distinction between private morality and public morality. People may disagree, on any given issue, where on the spectrum it falls. The Vatican instruction, for example, dealt with a great many moral issues, and when it came down to recommending what principles should guide civil law, it emphasized the two that I was talking about—the dignity of life and the integrity of families. Because these are things that are intrinsic to the common good of the society. If you start denigrating the value of life or if you destroy the family that's the basic unit of society, you're doing something more than just an immoral thing. You are breaking down the society that can make laws. You are acting against the principles that should guide good legislation.

In the area of ethics boards, I admit personally to being rather skeptical of them. Someone once said that if you want the moral IQ of an ethics committee you take the IQ of the average member of the committee and then divide his IQ by the number of members of the committee. I don't hold to that view. But there is, and I think deservedly so, a skepticism about the ability of committees as such to come up with principles on these things that are going to be acceptable to everyone in society. And in terms of federal advisory boards, I've noticed in the past that they do tend at times to be heavily weighted with people who are in the technical fields and have a vested interest in pursuing the technologies that are——

Mr. Hastert. Let me interrupt you. You have a problem with who becomes the experts on the board, what their expertise is, or who they are?

Mr. Doerflinger. Well, of course, who is on the board is going to be a big factor in what——

Mr. Hastert. We're kind of a federal advisory board here, too, I think in a sense and I'm sure that—I'm not sure that we could come up, Mr. Weiss or myself or whoever is over to the right of me, or the left of me I guess, could come up with absolute what is right and what is wrong. So I understand what you're saying. Thank you, Mr. Chairman.

Mr. Morrison. The gentleman from Florida.

Mr. Lehman. I think we have a very interesting hearing here. And I'd just like to think about the fact that we live in an ethical society; we live in a legal society; we also live in a mercenary or mercantile society.

And I don't know whether this story tells about the development of sexual attitudes or not. But a man goes up to this lady from society, and says would you spend the night with me for a million pounds? And she says, well, yes. And then he says would you spend the night with me for five pounds? And she said what do you think I am? And he says, I already know what you are I'm just trying to figure out the price. I think that that's an old story. You used to have YUPPIES, which were the young, upwardly mobile professionals. Now you have what's called TINKS, the two-income, no children. And these people are now in their late 30s. They divorce, they remarry and they are all of a sudden leaving the child bearing age and they want a child.

Recently I knew a young woman, healthy, attractive and very pregnant and not married. The time I saw her before the baby came, she had a wedding ring on. I said, "Are you married?" She said, "No." She said, "I had to wear this wedding ring because I was accosted by strangers on the subways who offered me up to 25, 30, 35 thousand dollars for this child, just walking up to me on the subway. And my obstetrician advised me for my mental well-being to wear a wedding ring to prevent this kind of verbal assault."

What you're really dealing with is what is going to be happening as you live in the real world out there, where people with the resources who want a child are going to find this child. And I would just like to perhaps ask Dr. Chavkin from the standpoint of a child, is the child really better off with two adoptive parents or is the child happier knowing that at least one of his parents is his biological true father? I think if I were a child, I would feel very much more comfortable, and I believe you have to tell adoptive children. I would feel a little more comfortable knowing that one of my parents was a real biological parent than to know that neither of my parents were truly biological parents. Is there, have you done any studies as to the actual emotional well-being of such children, or has it gone that far yet?

Dr. **Chavkin**. I don't think there are any studies yet about the children. I'm—in the realm of, you know, sort of personal speculation I could put forward the idea that it might be very troubling to a child to think that her or his mother had conceived them for the sake of a sale. I mean from my personal standpoint, I would find that much more troubling than to think that there were some tragic circumstances that led to my separation from my original, my biologic mother and that there were luckily other people who wanted to care for me.

Mr. **Lehman**. How many of the adoptions though are basically somewhat of a mercantile transaction?

Dr. **Chavkin**. Well, I think you're touching on something that's very important which is that in what they call the grey market of adoption; is not really all that different than surrogacy except that it might enter in a little bit later.

Mr. **Lehman**. That's what I'm talking about.

Dr. **Chavkin**. But we do have policy, I mean, on the level of policy formation, we do have policy that prohibits the exchange of money because we do have policy statements against the sale of babies and we don't wish to sort of implicitly seduce or coerce women into parting with the child for money.

Mr. **Lehman**. And are you saying it does happen and it's not such a rare occurrence.

Dr. **Chavkin**. Yes. And I think that is true——

Mr. **Lehman**. I have known lawyers for whom a good part of their practice is the arrangement of such transactions.

Dr. **Chavkin**. I know.

Mr. **Lehman**. We do not have a perfect society. And I think the first concern is the well-being of the child. And I just wanted to be able to establish the kinds of government participation or lack of participation where the child would be best off.

Dr. **Chavkin**. Well, then, one could, I mean I would go to my position which would not have a governmental prohibition in those voluntary cases where people make arrangements but where the government might put forth a policy that prohibits the exchange of hard cash so as not to promote those sorts of arrangements.

Mr. **Lehman**. Hard cash sounds so negative.

Dr. **Chavkin**. It was meant to.

Mr. **Lehman**. How about just transaction for the well-being of the biological mother?

Dr. **Chavkin**. Pardon?

Mr. **Lehman**. Hard cash sounds so negative. Sometimes hard cash can do a lot of good for the recipient. I have no other questions.

Mr. **Morrison**. The gentleman from New York.

Mr. **Weiss**. Thank you very much, Mr. Chairman.

First, let me express my appreciation to the distinguished members of this panel and indeed all of our witnesses today, for sharing their expertise and wisdom with us. I want to make special note of the fact that Dr. Chavkin is a distinguished public servant in the

City of New York, as the Director of the Bureau of Maternity Services and Family Planning for the City Department of Health as well as being a constituent of mine. So, welcome.

We have had reference to the OTA study that's under way and will be completed early next year, and that study was requested by the Human Resources and Intergovernmental Relations subcommittee, which I chair, as well as by two distinguished members of the Senate, Mr. Gore and Mr. Murkowski, because we knew that there were a lot of unanswered questions and there was a lot of information which ought to be pulled together. So, we're waiting, as you all are, for the results of that study.

We also have been confronted with other studies which sometimes don't do the kind of work that should be done. Our subcommittee has jurisdiction over the National Institute of Occupational Safety and Health, and they are prepared to undertake a study of the impact of video display terminals on pregnant women, especially on miscarriages and birth defects.

And because of pressure from one of our large corporations that is going to be the subject of that study, BellSouth, and pressure from the Office of Management and Budget, questions of how stress and infertility may be caused as a result of VDT use were removed from the study.

And it seems to me that when we're spending somewhere close to half a million dollars on that kind of study, where we don't have information about infertility, in the context of your statement, Dr. Chavkin, that we ought to be doing a lot more in prevention of problems which ultimately cause high technology to be sought as an alternative. We ought not to be squandering our resources in the fashion that we're doing.

And I'd like to have you expand on workplace concerns as well as the comparative costs of utilizing preventive measures as distinguished from the costs of the technological approaches that are being used.

Dr. **Chavkin**. Thanks for your welcome. For the record, I do wish to make it clear that I'm not representing the City of New York which has not adopted a position——

Mr. **Weiss**. We're aware of that. Thank you.

Dr. **Chavkin**. I share your feelings about the importance of NIOSH and other agencies continuing their research work. I'm not exactly sure how I can best tackle your question about workplace hazards but we do know that while we have not really begun to systematically or thoroughly evaluate workplace hazards on both male and female reproductive function, we do already know that there are such.

One example on some work that was in fact completed is that of lead, which is a reproductive toxin for both men and women and we are learning that—we are increasingly learning that that is the case at lower and lower doses and it is, as you know, a widespread exposure, not only in the workplace but in the atmosphere from leaded gasoline.

Mr. **Weiss**. Right. You also mentioned in your testimony that there could be preventive tests, for example, for sexually transmitted diseases. Would you estimate the cost of that kind of testing and preventive measure as distinguished from the numbers that

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were cited by you and the other witnesses for the costs of some of these more exotic procedures?

Dr. Chavkin. Okay. I'm not able to give you numbers off the top of my head though I would be able to supply them to you later. But there has been much written about the costs of neonatal intensive care, how fantastically expensive that is on each given day of hospitalization.

We could be instead directing our resources or as well directing our resources toward the prevention of prematurity which is what leads to most neonatal intensive care and we could do that through the provision of such inexpensive means as providing prenatal care and also exploring a variety of work-related policies that would enable say a working pregnant woman who needed to do so to have a temporary transfer to lighter duty without jeopardizing her job security or benefits.

Mr. Weiss. Thank you very much. Thank you, Mr. Chairman.

Mr. Morrison. Thank you. And I thank the panel very much for their testimony and for their answers to our questions. We'll move on to our second panel, if we might.

Our second panel will be John Robertson, who is a Baker and Botts Professor of Law at the University of Texas in Austin, Texas; George Annas, an Edward R. Utley Professor of Health Law at Boston University in Boston, Massachusetts; Lori B. Andrews, Research Fellow at the American Bar Foundation, Chicago, Illinois; and Robert Marshall, Director of the Castello Institute in Stafford, Virginia.

I thank the panel for making themselves available to us today and your written submissions will be made part of the record and if you would proceed to summarize your testimony and we'll go in the order that I called your name. Mr. Robertson.

STATEMENT OF JOHN A. ROBERTSON, J.D., BAKER AND BOTTS PROFESSOR OF LAW, UNIVERSITY OF TEXAS, AUSTIN, TX

Mr. Robertson. Thank you very much for the opportunity to be here. It is a pleasure to be testifying on the new reproductive technologies. And I think it's important to understand what is common to all of them.

What is common is that conception is noncoital—it occurs without sexual intercourse. Noncoital reproduction, whether of the in vitro fertilization variety or whether of the collaborative variety involving donors and surrogates, is significant because it enables infertile married couples to procreate and rear children that are biologically related to at least one of the partners and often biologically related to both of the partners.

Now, in this country we have a long tradition of privacy, of autonomy of married couples in matters concerning procreation, family and childrearing. It seems to me that this tradition of privacy in reproductive matters should extend to a married couple's choice of noncoital modes of reproduction as well. And what this means is that if state intervention occurs, it should occur only for the most compelling reasons, never on grounds of moral condemnation alone.

I'd like to explore this notion of procreative liberty a bit further because it's a centerpiece of any effort to explore policy in this area. And I don't think anyone would argue with the fact that a married couple has a right to reproduce by coital means. It's so well established that it's never even been challenged by the state in any way. I think we need to explore the implications of the married couple's right to reproduce coitally when they are not able to and need to use noncoital techniques.

Surely infertile couples should have the same right to bear, beget and rear children that fertile couples do, if the means for doing so or enabling them to procreate exist. A couple's interest in reproducing and parenting is the same whether they are infertile or not and as best as I can tell and estimate as a teacher-professor of constitutional law, I think our courts would agree with that when they are finally confronted with this question.

That means that restrictions by the state on noncoital ways of conceiving children have to meet the same high standard that restrictions on coital conception would have to meet, i.e., showing that the restriction is essential to prevent some tangible harm to others. Since moral condemnation alone would certainly not justify restricting coital conception, it should not justify restricting noncoital conception either. And this has important implications for an infertile married couple's use both of in vitro fertilization and assistance of donors and surrogates. Let me say something about each.

With regard to in vitro fertilization where the married couple is providing both the egg and sperm, but conception is occurring in vitro outside the body, it would seem that they clearly would have a right to use such a technique, as against state prohibitions, if it is necessary to do so. This technique is now well established as safe and effective. But it's important to recognize that their right to use that technique would extend to such things as creating more embryos outside of the body than could be safely transferred, for example, if they get six or seven eggs, fertilizing all six or seven and then transferring back only three or four, which is necessary for maternal safety, and thus freezing the extras for use on a later cycle. And I think their right would probably also extend to discarding or not transferring those embryos that would present a threat to safety and it probably would also extend to donating excess embryos to other infertile couples if there were such couples in need, and it might even extend to use of embryos that will be discarded in some research for valid medical reasons after review by an institutional review board and other review bodies, if that is appropriate.

Let me also say something about how this right of procreative liberty would apply to use of donors and surrogates, what I call collaborative reproduction. Obviously, no one reproduces alone, there's always a collaborator but here I'm talking about a third party collaborator outside of the married couple. And it would seem to me that if the infertile couple has a right to beget and rear children by the only means available that this would extend to making agreements with willing donors of sperm and egg and also willing donors of gestational services or surrogates, if that is necessary. And I think it's essential to recognize then that the agreements made with donors and surrogates concerning rearing rights and duties in the offspring of that arrangement should presumptively control. If the state prohibited such arrangements, refused to enforce the contract, or prohibited the payment of money to collaborators, the state would be interfering by making it extremely difficult or impossible for infertile couples to use these techniques, and thus would infringe upon their right to procreative choice.

Let me explain this point a little further, in the context of surrogate motherhood, currently so much in the public eye. It would seem to me that if we allow infertile married couples to use sperm donors and now egg donors that couples that are infertile due to uterine factors (in which the woman has functioning ovaries but has had a hysterectomy, has severe endometriosis, her mother had taken diethylstilbesterol during pregnancy and her uterus now cannot carry a child), those women also should have a right to have biologic offspring just as other infertile couples do and that as an essential part of that would include the right to agree with a third party surrogate to carry her embryo to term. Therefore it is essential that the agreement between the couple and the surrogate not be prohibited totally—that would clearly be an interference—if you could not pay money, that also would interfere with her exercise of liberty because it would mean that there probably would not be a surrogate available—and finally, that it would require enforcement of the surrogate agreement as well. The distinction that came up earlier between not prohibiting but choosing not to enforce, I don't think really works in this area because failure to enforce also represents an interference with their reproductive choice. If the agreement can't be enforced then people will be very reluctant to enter into it, just as one would be reluctant to enter into many transactions if there were not the certainty that the agreement would be recognized. In the situation where the infertile couple is able to provide an embryo to the surrogate, to say that the surrogate will not be held to her agreement to return it upon birth, would clearly be a direct interference with the couple's procreative choice.

I've talked about procreative liberty as a fundamental constitutional right of married couples, whether procreation occurs coitally or noncoitally. Of course, calling it a right doesn't mean that it's absolute, doesn't mean that it cannot be limited in appropriate circumstances.

However, the key point here is that not every public concern will count as a constitutionally sufficient reason for interfering with procreative choice. The state would have to show some serious tangible harm to others other than dislike or moral condemnation of noncoital and collaborative techniques to justify interference. As a result of this constitutional position, it seems to me that both the power of Congress and the power of the states to limit noncoital reproduction is very limited.

Let me give a couple of examples. The moral condemnation of all forms of noncoital reproduction contained in the recent Vatican statement would not justify state interference, no matter how strongly persons hold this view. Nor would a view that the embryo is a person from the moment of conception justify restrictions on embryo freezing, research or discard, again, because that's a moral position that would directly interfere with procreative choice. Nor is the concern that is often voiced and has been voiced by the prior panel about commercialization. Commercialization may not be a good thing but the kinds of concerns that have been expressed amount to a kind of moral condemnation of commercialization and that fact alone without some further evidence of tangible harm to others would not be sufficient grounds for restriction. The statement was made in a prior panel that we don't permit the selling of babies. And draws an analogy that we don't permit the selling of organs. Well, I point out, yes, we don't permit the selling of organs but we do permit the selling of organ transplants. For $50,000 you can get a kidney transplant; $100,000 a heart transplant and that sale includes the transfer of the organ and I think that's an appropriate analogy here. The question of selling reproductive services that lead to transfer of a baby seem to me to have a parallel in the sale of organ transplants even though we don't sell the organs themselves.

If we look closely at the other kinds of societal concerns that have been raised about noncoital reproduction, it's hard to find the tangible harm that people are concerned about. This is not to say that these concerns are not important and shouldn't motivate individuals in how they live their lives. But I'm not sure they rise to the level of tangible harm required to justify overriding procreative choice. Take the Baby M case where the surrogate mother changes her mind. Clearly she's feeling great disappointment and grief, but having agreed to something originally that would cause great grief in the hiring couple, it seems to me that concern for the change of mind in the donor of sperm, egg or surrogacy would not amount to a sufficient concern, nor would a societal judgment that there's something so sacred about the gestational bond that we should not allow a woman to alienate that in surrogacy. Again, that may be a very important concern, but it's a symbolic or moral concern that people differ about. And when there are differing views about the morality of reproduction then our Constitution requires that it be left to the individuals involved and not to the state.

I think there are a few areas where state intervention would be appropriate. One would be to make sure that reproductive collaborators are fully informed, counseled and knowing about the transactions that they enter into because if the original contract does have legal significance as I suggest, then contract formation is obviously a key stage. The state could take steps to make sure that people are well informed, counseled, have adequate representation at that stage.

What about protection of the resulting offspring? This is often raised as a major concern here and of course we cannot overlook them. Well, it's tricky though because if the restriction that aims to protect offspring leads to banning use of the technique altogether, you really haven't protected the offspring because the offspring then will not be born. And people who want to structure policy here on the welfare of offspring then have to choose methods that fall short of banning the techniques altogether because it hardly protects a child if your mode of protection means that child will never be born at all. Surely children born of collaborative arrangements, even if the unconfirmed speculation turns out to be true that they have some psycho-social problems, would find a life with some psychological problems not to be so desolate as to amount to wrongful life and to make the very bringing of this child into the world to be a serious harm.

There is one area, however, where I think a role for State involvement in reproductive contracts is appropriate.

And that is to assure that the identity of biologic, genetic and gestational parents is kept in a form so that the offspring can access it and learn who his or her genetic and gestational parents are at a later time. This kind of restriction on contract which would do away with anonymity and confidentiality in order to protect the offspring's interest in knowing who his or her genetic parents are I think is a very important area that has been overlooked and needs further attention.

Well, to conclude, the new reproduction does have important implications but I think to some extent they have been overblown because it's really a very small portion of all the reproduction that will occur. When we address the issue, it turns out that many of the concerns do not amount to the kind of tangible harm to others necessary to justify governmental intervention.

Many of the concerns are moral concerns or symbolic concerns, which may be very important to individuals, but do not form the basis for governmental intrusion into such important fundamental rights.

As a result, since use of these techniques involves the exercise of a basic procreative liberty, the role of government in regulating its use is necessarily minimal. As with decisions about coital reproduction, we must rely on informed decisions by the couples involved and the professionals advising them rather than the power of the state to assure that noncoital reproduction is used wisely for the good of couples, children and society.

Thank you.

Mr. MORRISON. We're going to break from our order for a moment.

The gentleman from Illinois has to leave and has asked if he could ask you, Mr. Robertson, one question, for a short period of time.

[Prepared statement of John A. Robertson follows:]

PREPARED STATEMENT OF JOHN A. ROBERTSON, J.D., BAKER AND BOTTS PROFESSOR, SCHOOL OF LAW, UNIVERSITY OF TEXAS AT AUSTIN, AUSTIN, TX

An extended analysis of the questions discussed here may be found in Robertson, "Embryos, Families and Procreative Liberty: The Legal Structure of the New Reproduction," 59 Southern California Law Review 939-1041 (1986).

I want to thank you for the opportunity to testify on legal and ethical issues that arise with the new reproductive technologies.

Noncoital reproduction--whether involving in vitro fertilization or the use of donors and surrogates--enables infertile couples to procreate and rear children biologically related to at least one rearing parent.

Intimate decisions about procreation, family and childrearing have traditionally been zealously protected against state intervention. The tradition of privacy in these decisions should also extend to noncoital modes of reproduction. State intervention should occur, if at all, only for the most compelling reasons, never on grounds of moral condemnation alone.

The Constitutional Right to Procreate

Any consideration of public policy for noncoital technologies must start with the premise that procreation by fertile or infertile married couples is a constitutionally protected right, subject to state limitation only for compelling reasons and not merely to express distaste or moral condemnation of an alternative style of reproduction.

Recognition of a right to procreate is hardly controversial if coital conception by a married couple is at issue. The dearth of legislation limiting marital conception by coitus reflects the importance society accords procreative liberty. The implications of such a right for infertile couples who need the assistance of physicians, donors and surrogates to form a family now needs examination.

Surely infertile couples should have the same right to bear, beget and rear children that are biologically or gestationally related to one or both of them that infertile couples do, if the means for creating such children exist. A couple's interest in reproducing and parenting is the same whether they are fertile or not. Thus restrictions on noncoital ways of conceiving children should meet the same high standard of justification that limits on coital conception have to meet. Preventing tangible harm to others might justify limitation. Moral condemnation alone would not.

Recognition of the infertile couple's procreative liberty has important implications for both (1) noncoital conception involving in vitro or external conception of embryos; and (2) collaborative reproduction involving donors and surrogates.

IVF Issues

With regard to in vitro fertilization (IVF), the infertile couple's right to create embryos externally through IVF as part of an attempt to initiate pregnancy would clearly follow, for it is a safe and effective technique to overcome tubal infertility. The right to use IVF should include the risk of creating more embryos than can be safely transferred to the woman's uterus at one time, with the excess discarded, donated to others, used in research or cryostored for later use.

Competing concerns include the well-being of children who may be born after external manipulation of embryos, and the symbolic devaluation that some persons perceive in externalizing the human embryo. In most instances these concerns would not justify restriction of IVF techniques designed to lead to the birth of a healthy child.

Donors, Surrogates and Collaborative Reproduction

With regard to collaborative reproduction, the right of infertile couples to enter into contracts with willing donors and surrogates for the sperm, egg or gestation necessary for birth to occur should also be recognized. To effectuate procreative choice, agreements with donors and surrogates should presumptively control rearing rights and duties in resulting offspring. Ignoring these contracts, or banning them entirely or when money is exchanged, would interfere with procreative liberty. In most instances the tangible harm necessary to justify restraints on a married couple's use of these techniques cannot be shown (see below).

Consider, for example, surrogate motherhood, currently so much in the public eye. Couples infertile due to uterine factors (hysterectomy, endometriosis, diethylstilbestrol or medical risks) should have the same right to enlist the aid of a third party collaborator as do those who lack sperm or egg. The agreement among the parties concerning the shape of the resulting family should control unless serious harm to the child would result. Banning or failing to enforce surrogate contracts would interfere with procreative liberty, since it would bar the infertile couple from rearing children to whom one or both partners are biologically related.

Limits on Procreative Liberty

While procreative liberty is a fundamental constitutional right, the right is not absolute and can be limited for sufficient cause. However, only substantial harm to third persons would be a constitutionally sufficient basis for restricting procreative liberty. Some serious tangible harm to others must be shown, rather than dislike or moral condemnation of noncoital and collaborative techniques. As a result, the power of Congress or the states to limit noncoital reproduction is limited.

For example, the moral condemnation of noncoital reproduction contained in the recent Vatican statement would not justify state interference, no matter how strongly held. Nor would a view that the embryo is a person from the moment of conception justify restrictions on embryo freezing, research or discard.

Other societal interests may also be insufficient. The interests of donors and surrogates in reneging on voluntarily-entered child-rearing agreements would not be a sufficient reason, even though their grief and pain is substantial. Nor could the state ban these contracts just to prevent the emergence of new forms of non-nuclear blended or extended families, to elevate a particular view of the gestational bond or to protect siblings.

The state could, however, regulate entry into collaborative contracts to assure that donors and surrogates are well-informed and freely consenting to reproductive arrangements that will have significant consequences for them and for offspring.

The state could also, in appropriate circumstances, regulate donor and surrogate transactions to protect the welfare of resulting offspring. Thus requirements that the identity of donors and surrogates be acessible to offspring interested in learning their genetic and gestational history may be a justifiable limitation on such contracts.

Screening of parental fitness, such as occurs in adoption, should not be standard practice for it is not ordinarily required of couples who reproduce coitally. Of course, physicians are not obligated to provide infertility services to persons who appear to be unfit parents. Nor would the use of these techniques give rearing parents any greater right to abuse or neglect children than they have with children conceived coitally.

Indeed, the question of protecting offspring is more complicated than at first appears. In most instances the offspring would not have been born but for the noncoital technique in question. Limiting the procedure to protect children hardly protects them if it prevents their birth altogether. Even if speculation that such children would have more psychological problems than other children proved true, their lives are not so desolate as to amount to wrongful life. From the offspring's perspective, banning these techniques to protect them or their siblings does not make sense.

Conclusion

The new reproduction has important implications for infertile couples, the reproductive roles of men and women, new forms of family and the children who are born as a result.

Since the use of noncoital technology involves the exercise of procreative liberty, the role of government in regulating its use should be minimal. As with decisions about coital reproduction, we must rely on informed decisions by couples and the professionals assisting them, rather than the power of the state, to assure that noncoital reproduction enhances the welfare of couples, children and society.

Thank you for your attention.

PROCREATIVE LIBERTY, EMBRYOS AND COLLABORATIVE REPRODUCTION

by

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This paper is an edited transcript of a talk given at York College, C.U.N.Y., in November, 1985. A longer version of it appears as "Embryos, Families and Procreative Liberty: The Legal Structure of the New Reproduction", 59 Southern California Law Review 501-601 (1986).
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Abstract

This article discusses the implications of a constitutionally protected right to procreate for a wide range of reproductive choices made possible by noncoital reproductive technologies, including embryo freezing and donation and surrogate gestation. After establishing the constitutional basis for a positive right to procreate, it discusses the extent to which concerns about the welfare of embryos, offspring, donors and surrogates justifies limitation on reproductive choice involving these technologies. While tangible harm to offspring and protection of the free choice of reproductive collaborators may justify regulation, moral condemnation of noncoital techniques and concerns about the reifying effects of their use are an insufficient basis for state restriction.

Procreative liberty has in recent years been most often discussed in terms of the negative right to avoid procreation by access to abortion and contraception. I want to discuss the positive aspect of procreative liberty--the liberty to procreate how and when one chooses--as it arises with technologically-assisted reproduction.

The positive right to procreate has not yet been extensively examined. The use of noncoital reproductive techniques now forces us to consider this aspect of procreative liberty. Developments in external fertilization and embryo transfer and the use of donors and surrogates requires attention to such questions as: is there a right to reproduce non-coitally? Is there a right to reproduce non-coitally with the assistance of third party collaborators? What limits on noncoital reproduction are within state or professional power? Do notions of reproductive responsibility justify limitation of noncoital reproduction?

I will briefly discuss the constitutional status of the positive right to procreate, and then examine how embryo status, concerns for offspring and family, and more general concerns with the reification of reproduction influence the scope of individual use of the new reproductive technologies.

The Constitutional Status of a Right to Procreate

It is reasonable to conclude that married couples in the United States have a constitutionally protected right to reproduce by sexual intercourse. No laws have ever restricted marital reproduction and few court cases even discuss the issue. The state has never tried to interfere with the right of married couples to reproduce by coitus.

Two points that have great significance for the new reproductive technologies follow from constitutional acceptance of a married couple's right to reproduce coitally. First is the right of the married couple to reproduce non-coitally as well, through such means as artificial insemination with the husband's sperm or through extra-corporeal fertilization--the IVF process. Second, is the right to reproduce noncoitally with the assistance of donors and surrogates. If one or both partners lack the genetic or gestational factors necessary to procreate, it should follow that they have the right to enlist the willing assistance of donors and surrogates to provide the gametes or missing gestational function. Careful attention to the precedents, values and interests that support protecting coital conception should lead to similar protection for noncoital reproduction.

If this analysis is correct, couples would have a constitutional right (e.g., a right against state interference with or prohibition of their actions) to create, store, transfer, donate and possibly even manipulate extra-corporeal embryos in order to acquire offspring of their genes or gestation for the purpose of rearing as their child. Contracts with gamete and embryo donors and surrogates would also be constitutionally protected. Only very important state interests, such as tangible harm to other persons, would justify restricting noncoital and collaborative reproductive variations. Moral distaste alone would not be a sufficient ground for limiting procreative liberty, even though moral distaste might legitimately animate the private sector decisions of patients and physicians.

The implications of this analysis for collaborative reproductive transactions needs special emphasis. It suggests that the contract among the parties concerning rearing rights and duties in offspring is presumptively controlling. Giving legal effect to the agreement that couples make with third-party collaborators limits state intervention to regulating the conditions of entering into such contracts, and leaves little room for restricting the substantive bargains struck among the parties. However, some restrictions to protect offspring may also be within the state's power.

I have emphasized the right of married couples because their right to reproduce is so firmly established in American law. One can make a very strong argument for unmarried persons, either single or as couples, also having a positive right to reproduce. This has not yet been explicitly recognized in American law. However, if their right to coital conception is recognized, then single and unmarried persons should have the same rights to reproduce non-coitally and with the assistance of donors and surrogates that married couples have.

This analysis of procreative rights answers many, but not all questions that arise concerning use of the new reproductive technology. The constititutional structure provides a framework that accords high value to procreative choice, but answers to specific disputes and problems may ultimately depend on the meanings people find in the reproductive roles that non-coital technology makes possible. One set of questions arise about the scope of partial reproductive roles. A woman now can be an egg donor, just as a man may be a sperm donor. A woman may also choose as a surrogate gestator to experience gestation without having a genetic tie with the offspring. What limits, if any, should be placed on women playing such partial reproductive roles?

Another set of questions concerns the right to reproduce posthumously through postmortem thawing of cryopreserved eggs, sperm and embryos. Do those partial reproductive roles deserve the same respect and protection that reproductive roles that aim at producing offspring to be reared deserve? Answers to these questions will depend on the meanings that people find in such experiences, and their relation to the interests and values that underlay the positive right to procreate.

Embryo Status

Let me turn now to various interests that have been put forward as grounds for limiting the positive right to procreate. One set of interests concern preimplantation embryos. Concern for embryos has led some persons to support restrictions on what might be done with embryos. Such proposals require us to assess the legal and moral status of the extra-corporeal embryo. Does the preimplantation embryo at any of its stages from fertilization, through zygote and blastocyst, have legal or moral rights that limit what the gamete sources or others might do with it? What is the nature and moral status of this living, embryonic entity? We must address these questions to resolve the locus and limits of decisional authority over preimplantation embryos.

Given the biological status of preimplantation embryos (described at p.), I have difficulty viewing the preimplantation embryo as a rights-bearing entity by virtue of its existing characteristics. Whatever one thinks of the fetus at a later stage of development, the one or two or four or eight-celled embryo is not an entity that possesses rights by virtue of its present characteristics. The preimplantation embryo lacks even the rudiments of a nervous system. It is not sentient, and is no more conscious than any other group of cells. Some religious and right-to-life groups view the preimplantation embryo as a "person", but I think this view is mistaken, at least if we regard "person" as a being that is capable of cognition and consciousness and interaction. The embryo lacks even the most rudimentary characteristics that a person or any rights-bearing entity would have.

However, the embryo might still be accorded value on as a symbol of human life generally. I want to make a distinction between owing the embryo respect by virtue of its existing characteristics, and according respect because of what it might become. While the embryo in itself may not yet be a rights-bearing entity, it clearly has the potential to attain the characteristics of persons, if certain contingencies occur. Persons may choose to invest the embryo with meaning as a symbol of human life generally, even though justice does not require that we protect it in any particular way. Particular efforts to demonstrate this respect for this symbol, however, must still meet constitutional standards.

If this analysis is correct, then the validity of limits on embryo manipulations depends on whether the embryo is going to be transferred to a uterus and thus has a possibility of implanting, going to term and coming into being as a child. In that case embryos have a special legal and moral status, not in and of themselves by virtue of their present characteristics, but because of what they may become. Activities with embryos that may be transferred to a uterus could directly affect resulting offspring. The body of law that recognizes prenatal obligations to offspring and permits sanctions to be imposed on persons who knowingly or recklessly harm born children by prenatal actions is relevant here. This body of law would impose responibility for embryo manipulations that could foreseeably harm children born after transfer of such embryos to a uterus and their eventual birth.

Where transfer to a uterus is not planned or desired, the question of embryo status per se in my view is symbolic, rather than a matter of rights. What legal and moral status does the embryo have if it is not going to be transferred? This question is of importance with regard to the permissibility of research with nontransferred embryos, and the permissibility of destroying or not transferring embryos that are unwanted by the gamete egg source. Because of space constraints, I will discuss only the question of not transferring unwanted embryos to a uterus.

Is there a moral or legal duty to transfer all embryos to a uterus so that they might have the chance to implant and come to term? At present there is no such legal duty, and few commentators who do not view the fertilized egg itself as a human subject with rights find a moral duty to do so. I would argue that nothing is owed the preimplantation embryo in itself. It is too rudimentary to be the object of justice in its own right. Persons may, nonetheless choose to invest the embryo with value as a symbol of human life generally, even though there is no moral obligation to do so.

The current practice in most of the 120 American IVF programs is to transfer all embryos to a woman's uterus. Although not legally required, this practice has developed for various reasons, including a desire to avoid controversy with right-to-life groups over abortion. Yet this practice now poses potential conflicts with the wishes of the couples providing the egg and sperm. The standard IVF regimen stimulates the production of multiple eggs. If more than four eggs are retrieved and fertilized, placement of all in the uterus produces a high risk of multiple gestation. To avoid this risk, it might be necessary to discard some of the embryos. Cryopreservation may postpone the decision, but eventually the question will arise, since transfer of stored embryos at a later time may not be possible.

Persons who believe that the embryo itself has rights or that a symbolic statement about respect for human life should be made might support mandatory embryo donation laws. Such a law might read: "All extra-corporeal embryos that the woman who provided the egg does not want to have transferred to her must be transferred, with her anonymity guaranteed and no rearing duties imposed, to a willing recipient." Would a mandatory embryo donation law be constitutionally acceptable? Such a law does not violate a woman's right to have an abortion because it does not require that a woman accept placement of an embryo in her uterus. It would, however, lead to unwanted biologic offspring. Yet if no rearing rights and duties attach, and the donation is anonymous, the interest in avoiding unwanted biologic offspring might not be accorded constitutional protection.

Resolution of this conflict turns on our valuation of an unwanted biologic link tout court. Is that a matter of great personal significance to individuals, so that a genetic link should not be created unless they consent? Or is that a minor concern that does not merit public protection when it is anonymous and imposes no undesired rearing rights and duties?

The answer to this question will evolve with the different uses to which this technology is put. The legal issue may ultimately require the Supreme Court to decide the matter. In my view, the most desirable practice is to transfer all embryos where reasonably possible as a way of demonstrating respect for life generally. However, if people who have provided the genes for the embryo object, I think it probably best to leave the final decision with them. The symbolic gains from embryo rescue is outweighed by the source's wish to avoid an unwanted genetic connection. However, constitutionally, the state may be found to have authority to require donation of unwanted embryos, when no rearing duties are imposed on the genetic parents.

This discussion of embryo status reminds us not to assume that our views about abortion automatically indicate answers in the significantly different area of IVF and extracorporeal embryos. The embryo differs from the fetus in two significant ways. The embryo is substantially less developed than a fetus, without organs, a brain or the most rudimentary cellular units of the neuromuscular system. One could logically be against abortion on the grounds of respect for the sentience of late-term fetuses, and at the same time hold that preimplantation embryos may be discarded by the gamete source.

The second point of difference is that the extra-corporeal embryo, unlike the fetus, is not inside a woman, is not making demands on a woman's body. Therefore, one could be in favor of abortion, of allowing the woman to expel the fetus, and still permit state intervention to protect extracorporeal embryos by requiring their donation to willing recipients because of the symbolic importance of demonstrating respect for human life in this way. Mandatory embryo donation does not impose physical burdens on a woman as anti-abortion laws would, and thus needs to be analyzed in terms of the impact of an unwanted genetic link.

Family and Rearing Issues

Another set of concerns with the new reproductive technologies arises from a feared effect on families and offspring resulting from collaborative reproductive transactions with donors and surrogates. The concerns here do not arise when IVF is confined to a married couple, which it now largely is, but they arise from the collaborative arrangements that IVF now makes possible, such as egg and embryo donation and the use of surrogate gestators. The fear is that new genetic, gestational and rearing combinations, made possible by the technical ability to fertilize eggs externally and transfer them to any physiologically receptive uterus, will confuse the child, confuse the parents, indeed, confuse all of us, and place further stress on the nuclear family.

These arrangements may not be as novel as they first appear. In many respects, they are not drastically different from existing social arrangements that separate genetic, gestational and social parentage. Artificial insemination by donor, adoption, stepparentage and various forms of blending families after divorce or death present many of the same concerns, but have been assimilated into the social fabric. Creating further variations through egg donation, embryo donation and surrogacy are not radically different and should be treated accordingly. Indeed, in many cases these variations provide genetic or gestational ties with the offspring that do not exist in artificial insemination by donor, adoption or stepparentage.

It is essential to distinguish the impact on offspring from concerns about the donor or surrogate, or more general concerns about the family. There is a pervasive, though in my view confused, feeling that these arrangements must be harmful to offspring who are born as a result. The problem with this kind of argument is that if it were not for these novel collaborative arrangements, the offspring would never exist. Even if their life is somehow more fraught with psychological difficulties and suffering than the life of the ordinary child, it is the only life possible for them. Prohibiting collaborative transactions thus does not protect the child, for the child would never come into being at all. Psychosocial confusion, even genetic bewilderment, is an acceptable price for the offspring to pay in order to exist at all.

I would argue that couples have a constitutional right to engage in collaborative transactions with donors and surrogates. If married couples (and possibly unmarried persons) have a right to procreate, that right should include the right to make contracts with providers of gametes and embryos and with gestational surrogates, if that is essential to enable them to reproduce and acquire a child of their genes or gestation for rearing. The positive right to procreate thus allows married couples to contract for eggs, sperm, embryos, or surrogates, with the agreement among the parties presumptively settling rearing rights and duties toward the offspring. Unless a tangible harmful impact on offspring or others is demonstrated, such contracts could not be prohibited or limited, though they could be regulated to assure that they are knowingly and freely entered into.

Let us briefly explore these issues with egg and embryo donation and surrogate gestation. It is now possible for women to donate eggs to other women, and thus have genetic offspring without gestating themselves, at the same time that the recipient may gestate and rear a child that is not genetically related to her. Artificial insemination by donor has a well-established niche in infertility treatment for men. The provider of sperm usually gives up all rights and duties with regard to the resulting offspring (which may present some problems for the offspring). Is there any reason why women should not also be able to donate gametes? Indeed, offspring born of egg donation will have a gestational tie with the mother even though she is not the genetic parent. The same rules that regulate rearing rights and duties in the offspring of sperm donation should apply to egg donation as well, e.g., the agreement between donor and recipient for rearing rights and duties in offspring presumptively controls.

IVF technology allows the extra-corporeal embryo to be implanted into any physiologically receptive uterus, thus making embryo donation possible. Embryo donation is not yet widely practiced, but will occur on a wider scale once the freezing of spare embryos becomes more developed. Embryo donations might also arise from uterine lavage of a blastocyst (an embryo at the 60-100 cell stage) from the uterus of an woman and then transfer of that blastocyst to the womb of another woman. And, of course, laws may develop that mandate donation of unwanted embryos. The question is whether there should be limits or restrictions on embryo donation? Should not the contract between donor and recipient also control?

It is important that we call this procedure an "embryo donation" rather than "embryo adoption." Use of the term "embryo adoption" smuggles in a hidden value assumption about the nature of the embryo, by analogizing the embryo to an adopted child, when it may never implant in the uterus, much less complete the long journey to a term delivery. Embryo donation should be treated like coital reproduction or artificial insemination by donor, where no agency or court review to assure the fitness of parents is required.

A general issue that arises with embryo donation and gamete donation is the question of anonymity and secrecy of the source of the donated embryos and gametes. Can the parties who donate the embryo and the receivers agree among themselves to maintain confidentiality so that the offspring will never know its true genetic origins? Even though the parties agree to confidentiality, the needs of persons born of gamete or embryo donation to know their genetic parents may override the interest of the contracting parties in confidientiality. In this instance the agreement of the reproductive collaborators to maintain a secret would be justly overridden to protect the offspring's interest in knowing his or her genetic roots.

A final point about embryo donation is sale. Should people be able to sell the embryo or recoup some of the costs of producing it? Producing excess embryos by IVF is expensive and arduous. Payment beyond sharing in the medical costs, however, is objectionable to many persons. Some would argue that embryos should not be sold, and should be treated like organs -- hearts, livers, kidneys -- which we do not allow to be sold for transplant. But banning payments might interfere with a couple's ability to obtain an embryo, and thus infringe their procreative liberty. Unless sale is connected with tangible harm to other persons, the moral or symbolic offense that some persons might find in such transactions is not a sound basis for restricting procreative liberty by banning sale of embryos.

Another troubling reproductive transaction concerns gestational surrogacy, the other major collaborative variation that extra-corporeal conception now makes possible. If an extra-corporeal embryo can be transferred to any physiologically receptive uterus for gestation, the gestating woman could choose merely to gestate, and not rear -- that is, to return the child, once born, to the persons who provided the embryo in the first place. At least one child from such an arrangement has been born in the United States.

Gestational surrogacy does not include the current practice of "surrogate mothering" that has led to such controversies as the Baby M case recently litigated in New Jersey. That form of surrogacy involves the surrogate's preconception agreement to be inseminated, carry to term, and then relinquish the offspring to the father and his partner for rearing. Surrogate gestation, by contrast, involves a preimplantation agreement with a woman to accept placement of an already created embryo in her uterus for gestation, and then to return it to the genetic parents at birth for rearing.

Surrogate gestation is troubling because of the attitude that it seems to take toward the gestational maternal bond. The willingness to divorce gestation from the usual maternal caring and rearing that occur after birth appears detached and cold, and signifies a willingness to use women as gestational vessels.

But gestational surrogacy should also be viewed from the perspective of the woman or couple seeking such reproductive assistance. The strongest demand for such a service would arise from women who are barred by medical factors from gestating their own offspring. A woman may have functioning ovaries, but have had a hysterectomy and not be able to bear a child. Or a woman may have a uterine malformation due to administration of diethystilbesterol to her mother that makes a successful pregnancy impossible for her. Thus there are legitimate medical reasons why a woman who cannot bear a child but who is able to produce an egg, may want to engage a surrogate gestator. Some persons find this need for a surrogate to be more compelling than reasons of so-called "convenience," where the woman could medically bear the child herself, but for work, life style, leisure and other reasons would prefer not to.

Since hiring a surrogate gestator is an exercise of procreative liberty on the part of the couple, there is a strong case for a constitutional right to employ a surrogate. Prohibition of such arrangements would interfere with the woman's and couple's right to procreate, for there is no other way for them to have offspring of their genes. Harm to the offspring or the surrogate does not appear great enough to justify limitation of the arrangement. Indeed, the main concern appears to be a desire to prevent symbolic harm to deeply-felt notions of motherhbood and the importance of the gestational bond. Treating the gestational bond as something to be manipulated and used for selfish purposes -- the willingness to gestate a child and then coldly detach oneself from it -- may be highly distasteful to many persons and are legitimate concerns for guiding one's own behavior. But they are not a sufficient basis for public action limiting the procreative choice of willing parties. They should not override the couple's right to procreative liberty and a woman's right to find procreative meaning by serving as a surrogate gestator.

If surrogacy agreeements are permitted, they must also be enforced--by money damages if not also by specific performance. Could the surrogate abort or refuse to turn the child over at birth? The argument for allowing the surrogate to renege is weakest when the surrogate is gestating the embryo of another couple. Perhaps she should be free to abort, but if she does, she has breached her contract and destroyed the couple's embryo, and should at least have to pay damages to the couple. One could also argue that she should have to relinquish the child to the genetic parents as the original agreement stated, even if a surrogate who has also provided the egg would be free to keep the offspring. It is the genetic offspring of the hiring couple that is at issue. The surrogate would not have received their embryo for gestation unless she had agreed to relinquish it at birth. Regarding her as a trustee who then must turn over the child should be acceptable, and may even be constitutionally required.

The question of paying surrogates is also controversial. Once again, the concern is primarily symbolic--distaste at the notion of renting a uterus, and treating women as a uterine function for hire. Beyond the symbolism of hiring gestational vessels is a concern that poor or minority women would disproportionately serve as surrogate gestators. The fear is that poor women would end up bearing the gestational burdens of the middle and upper classes. However, if payment is the only way a couple could produce a child of their own genes, and the surrogate accepts knowingly and freely, there is a strong constitutional argument for permitting payment to surrogates. A prohibition on payment would interfere with this reproductive option, and thus deny couples medically barred from gestating from having and rearing biologic offspring.

The Reification of Reproduction

The new reproductive technology is also troubling because of fears that it will lead to Brave New World scenarios and the ultimate reification of reproductive functions. Several issues are conflated in these concerns. One is the fear of technology gone awry and used by government to oppress and enslave. This fear is captured in the frequent reference to Huxley's Brave New World, in which children are genetically programmed, produced in laboratories, artificially gestated, and decanted from bottles, already programmed for specific social roles.

A less apocalyptic version of this fear may be expressed as a concern with overtechnologizing intimate human functions.

The concern is that we undermine human dignity by subjecting the reproductive process--the very creation of new human beings-- to scientific, technical, rational procedures. IVF bombards the ovaries with powerful drugs, invades the body to retrieve eggs, fertilizes eggs under the light of the laboratory sun and not in the dark recesses of the fallopian tubes. Yet it is unfair to single out IVF and other new reproductive technologies for these complaints, since similar operations are inherent in science generally, and medical science in particular. Medical science objectifies and manipulates nature for human purposes.

Furthermore, objectification is inherent in the standard array of infertility treatments now widely accepted. The body is viewed and treated as a kind of technical apparatus to produce gametes and children. Seen in that way, there is nothing distinctive about IVF. It is just an extension of what we do in science, medical science, and infertility therapy generally. Unless we're going to banish all of them, IVF cannot be banned on this ground.

Yet another formulation of the concern with the reification of reproduction focuses on its impact on women. Obviously, only women can ultimately tell us what this impact is. But feminist thinkers are just beginning to address the new reproductive technology, often critically.

Some feminists emphasis the dark side of the new reproductive technology. They deny that it is liberating as long as women still gestate, for it still binds women to biologic reproductive roles that men escape. True liberation for women would be to reproduce and avoid the burdens of gestation and the concomitant burdens of early child-rearing with which gestation is closely linked.

Furthermore, IVF and its collaborative variations, in focussing on the woman as an object to be made fertile, still assumes that a woman's main function is reproduction, and thus reinforces the overidentification of women with biological function. By operating on the woman's and not the man's body, IVF reinforces the notion that the woman is primarily a child-bearer. In this sense, playing more limited or partial reproductive roles as egg donor or surrogate are even more troubling, since they identify the woman with this one aspect of her biologic functioning. Femininists also object to the exploitation and reification of women as gestational vessels that occur with surrogate gestation.

The feminist concerns with the dark side of the new reproductive technology should not be ignored, but I do not believe that they are sufficient to outweigh the benefits to women and men of enhanced choice over fertility. They do remind us, however, of the abuses and problems that are possible, and thus the need to attend to using these techniques carefully.

It seems to me that there is a positive side to the new reproductive technology that femininist criticism has tended to overlook. Extra-corporeal conception seems to promote choice, to promote the autonomy of women (and men) in helping them overcome infertility, which for many women (and men) is a very serious problem. Just being able to have a child and become a parent is a major achievement. These techniques also indirectly support female social roles that might induce infertility, such as postponing childbearing for career or life-style reasons to a time when fertility is greatly lowered.

Extra-corporeal conception also gives women potentially greater control over selecting which embryos will be transferred, thus avoiding the very difficult choice that Barbara Katz Rothman discusses in The Tentative Pregnancy of undergoing prenatal diagnosis and abortion to avoid a serious genetic defect in offspring, a very stressful experience. IVF provides a window on the embryo that will eventually enable prenatal diagnosis to occur before implantation, and thus avoid the stresses of abortion on genetic grounds later in the pregnancy.

Finally, IVF technology makes possible new, partial reproductive roles for women. While many women will want to rear their own biologic offspring, some women may find partial reproductive roles as egg and embryo donors and surrogates to be meaningful option that fits best into their life plans.

However one evaluates the potential impact on women, in the short run the new reproductive technologies pose problems that consumers of medical services generally face. IVF presents the traditional problems of male-dominated obstetrics and gynecology that liberal feminist critics have long decried--the exploitation of women as health care consumers. Questionable uses of hysterectomy, mastectomy, cesarean section and other high tech obstetrical practices have been justly criticized. Similar concerns may be voiced about the use of IVF, even without its fancy variations, for it is an expensive and stressful experience that often will not produce the baby that the couple so strongly wishes. Yet couples might be misled into thinking that this technology will solve their fertility problems. Most American IVF programs have not yet had a pregnancy, yet many couples are not fully informed of the rather low chance of success. Some IVF programs may thus be exploiting the vulnerability of infertile couples, with the woman bearing most of the burden of physical manipulation. In the short run the most important issue about the new reproduction for women might be to assure access to competent, skillful services and fully informed consent.

Conclusion

In the final analysis, the new reproduction presents a clash between individual autonomy and the social implications of individual procreative choice. In the long run social changes could occur from many discrete, individual decisions to use this technology. Yet fear of these long run consequences should not limit short run use. Since a basic constitutional right -- the right of infertile persons and couples to procreate --is at issue, the state is limited in the measures that it can take to influence the exercise of this right in the private sector.

It may be that many persons exercising their rights will end up changing the values now dominant in society, leading to a new set of procreative values and behavior. But that is the recurring dilemma of liberty in liberal society. The exercise of protected rights may eventually change values and practices throughout the social order. Under the American constitutional scheme, individual discretion over use of the new reproductive technology is protected, even if the exercise of freedom ultimately reshapes the society providing that freedom.

Mr. HASTERT. I appreciate the Chairman's indulgence and do appreciate your testimony.

I think you've been very logical in your approach and I guess when you get the members of the Bar up there you can do that.

Let me ask you a couple questions. You said that this issue is really an issue of procreative liberty and it provides the ability of noncoital reproduction to nonmarried individuals and basically I think you went through a whole litany of things that applies to law and you basically underlie with legal doctrine and case law.

Basically then do you agree with me or disagree with me in at least this statement that this issue is really decided on a basis of law? Otherwise, when you're talking about the Ethics Advisory Board, the questions really before people are legal issues and individual's rights issues and how they affect the law?

Mr. ROBERTSON. It's a question of law when we're asking what the scope of individual choice in this area is. The most basic question is are individuals, infertile married couples, to be the primary decision makers or is the state to come in and limit the choices they can make. So in that sense it's a very basic question of constitutional law.

Mr. HASTERT. Are you saying then probably the advisory board's limitation is to decide what's legal and what's not legal in the view of what law exists?

Mr. ROBERTSON. No, on that I would respectfully disagree, that the role of an ethics advisory board or the new bioethical, Congressional Bioethical Review Board, which I think is probably the more appropriate body now for addressing many of these issues, would not necessarily be to decide what's legal or not but to decide within the parameters of permissible state intervention what types of intervention would be desirable or not.

Mr. HASTERT. But you did say that there's going to be differing views and when you start to get in ethical, religious, moral views, that's really an issue of individual choice and really outside of the perspective of that board.

Mr. ROBERTSON. Well, such a board could canvass such views to see if there is a developing consensus, to see how split views are and may be able to inform us about——

Mr. HASTERT. But basically you'd say those individual choices are individual choices and certainly should remain that way and not be parameters of the legal view of the board?

Mr. ROBERTSON. As a matter of constitutional permissibility of doing certain things, yes, it ultimately would be up to private choice but there's still a lot of room for governmental intervention. For example, Congress could choose to fund or not fund research in this area without interfering with constitutional rights. There's no constitutional right to be funded so if Congress chose not to provide funds that would be something that might be acceptable. It would clearly be acceptable as a constitutional matter. Whether it's acceptable as a policy matter might be determined by the advice of such a board.

Mr. HASTERT. But ultimately value, we look to the legal value here and even the issue, the great issue before us a couple months ago, as to Baby M, where should she go, it's settled as a process of law and ultimately it will be a process of law and the board makes those decisions, right?

Mr. **Robertson**. At the most fundamental level, when we come down to controversies about whether private choice should control the rearing rights and duties in the offspring I think that fundamental level is a matter of law and will be decided as such.

Mr. **Hastert**. Mr. Chairman, I appreciate your indulgence.

Mr. **Morrison**. I appreciate having your questions. Thank you. If the panel could continue, with Mr. Annas.

STATEMENT OF GEORGE ANNAS, J.D., M.P.H., EDWARD R. UTLEY PROFESSOR OF HEALTH LAW, BOSTON UNIVERSITY, BOSTON, MA

Mr. **Annas**. Thank you, Mr. Chairman. Thank you for inviting me to address the legal and ethical aspects of regulating the new reproductive technologies.

I was especially pleased to be invited to testify today because I believe the public debate over these issues has been characterized primarily by emotionalism and dogmatism with little attempt to place the issues in a broader context and little attempt to make necessary distinctions.

I am very pleased to be on the panel with Lori Andrews and John Robertson, however, who have been notable exceptions to that general rule. Although there has been even with these two commentators very little consideration for the best interest of the resulting children.

It is the purpose of my brief remarks to suggest a more coherent framework for analysis and to make two specific suggestions for legislative action, one at the state level and the other at the Federal level.

Each of the new reproductive technologies could be viewed individually, but it is however, more analytically fruitful I believe to identify and explore their common characteristics relevant to public policy since other methods will undoubtedly be developed and permutations of existing methods can also be used.

Thus unless we are to have a separate policy for each method, an unlikely and ultimately unproductive response, like having a separate public policy for each form of treatment for cancer, we will have to identify the characteristics that each of these methods share that make regulation important and useful.

The characteristics shared by some or all of these methods are potential for non-infertility use; protection of the extra-corporeal embryo; legal identification of the mother; legal identification of the father; screening of the donor; anonymity; record keeping and access by the resulting child to records about the donor; and opportunities for commercialization.

The paramount social policy issue raised by this group of new reproductive technologies is their medical nature and the applied medical indications of potential for non-infertility use. The issue of protecting the extra-corporeal embryo applies only, of course, when such an embryo is produced and this will occur in in vitro fertilization and surrogate embryo transfer.

The issues of parental identification, donor screening, donor anonymity, and record keeping, will arise only when more individuals other than the married couple are involved in producing gametes for the resulting child. More specifically, in artificial insemination by donor and use of a surrogate mother. Of course if you would employ donor gametes in either GIFT or in vitro fertilization, and the same issues will arise in these as well.

When reviewing the legal options for regulation on both the State and Federal level, it will be useful to keep in mind pressure points at which regulation can and has traditionally been brought to bear. In general these will be control of medical practice, control of human experimentation, defining the presumptive rearing father and mother, granting legal protection to the extracorporeal human embryo, legal provisions for donor screening and record confidentiality, regulation of commerce in gametes and embryos, and attaching conditions to the delivery of medical services that are paid for in governmental programs.

Since the regulation of both medical practice and family status is primarily a state function, regulation of the actual delivery of these technologies is almost always primarily a task of the individual states.

States could, however, also regulate the new reproductive technologies indirectly by statutorily defining which woman, as between a gestational, genetic and planned-for rearing mother, would have the presumptive rearing rights and obligations with respect to the child. And here I believe strongly that states should enact statutes that clearly define the gestational or birth mother as the irrebutably presumed mother for all legal purposes. This is because of her gestational contribution to the child and the fact that she will definitely be present at birth, be easily and certainly identifiable and available to have responsibility for the care of that child.

I believe Professor Robertson's analysis focuses exclusively on the right of the infertile woman who is the ovum donor, and the key to resolving this issue is really the rights of the resulting child and that right to have someone responsible for it at the moment of birth, and secondly, the comparative rights of the gestational or birth mother.

Professor Robertson argues that if we don't enforce the rights of the contracting mother (who would like to be the rearing mother), that couples would be reluctant to enter into this agreement. Well, I quite frankly think that's too bad. I don't think couples have a legal, have a constitutional right to enter into these agreements, if it's for the detriment of the child. The child's welfare in situations like this can only be assured if we know someone is going to be available at the birth of that child to take responsibility for it. Indeed, the woman who gives birth to the child has her own procreative liberty. I do not believe it would be constitutionally permissible to enforce a contract that requires the police to come and bodily remove the child from its mother, the woman who gave birth to it, after she has decided that she wants to rear that child. That should be as much an unconstitutional interference with her procreative liberty as it would be to require the courts to enforce a contract in which she agreed not to have an abortion during the term of pregnancy.

I believe the courts could not constitutionally enforce that contract and I believe the courts cannot constitutionally force a contract that requires her to give up the child if she no longer wants to give the child up at or immediately after the birth.

Congress—now that's a State issue. Congress, on the other hand, can act in areas where the Federal government has indirect authority and these have been primarily in taxation, spending and interstate commerce. We've heard a lot about the main area that Congress has used its power to spend and that has been in the area of research on human subjects. And I won't go into that area at all. I think that has been covered quite well.

The second area is regulation of interstate commerce, and that area can, and I think should, involve a ban on, a total ban on the sale of an article. Congress, for example, has indicated its willingness to ban the purchase or sale of human body parts and could certainly ban the interstate sale of human embryos and sperm and ova as well, if it wanted to. In 1984, Congress passed the "National Organ Transplant Act." And while most of the Act is aimed at promoting organ transplantation in the United States, and Professor Robertson is certainly right about that, Title II is directed exclusively toward prohibiting organ purchases. Its operative section reads:

> It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

I believe that Congress should amend this statute to include human embryos among the items that it is unlawful to sell. The purpose would be to protect the children, all children, not just the children involved in the new reproductive technologies, by preventing them, the babies and the resulting children, from being viewed as commodities to be purchased and sold.

This is not an issue, and I think Professor Robertson's comments on this point should not be taken terribly seriously, that the resulting children of these technologies wouldn't be born at all if it wasn't for the technology, therefore we don't have to protect them or that their interests do not rise to the level of protection that we give to all other children. That of course is an argument that proves way too much.

None of us would be born had not the specific egg and sperm that resulted in us come together and resulted, after gestation in our mother, in our birth. But the fact that we wouldn't have been born but for this doesn't mean that society, Congress and others can't and don't have obligations to take steps to protect the welfare of all children who are born, not just children born of high-tech, low-tech, or any other tech. None of us would be here but for some real accident of our birth. And the fact that we wouldn't be here does not mean that therefore we don't have any rights, or more importantly, that society doesn't have any obligation to protect the interests of children.

Professor Robertson is, of course, correct that the right of privacy does encompass many things and indeed it encompasses decisions to use contraceptives, not to be sterilized involuntarily (except perhaps when it is the least drastic alternative and in the person's best interests), and to use contraception and to obtain an abortion. That is, we have a right not to beget or bear a child. The Court has been very clear on this.

The question, of course, is whether this right will be expanded to include an affirmative right to actually parent a child, will be stable or will be contracted.

Although the U.S. Supreme Court is badly split on the reach of privacy outside of a heterosexual union, there is no such split concerning privacy within a heterosexual union, at least when that union is aimed at procreation.

All members of the Court currently agree, and will be thus likely to conclude that things like in vitro fertilization and GIFT, if conducted within the context of a marriage and using the gametes of the married couple, are to be viewed within the gambit of the right of privacy, the right to procreation.

Accordingly, I would agree with John Robertson that only laws similar to those endorsed by the Supreme Court to regulate previable abortions, that is those aimed at primarily restricting the performance to a physician, monitoring the safety and efficacy of the procedures, and assuring informed consent, could be used to regulate these activities.

In artificial insemination by donors, surrogate embryo transfer and surrogate motherhood, regulation could be much stricter since these involve another participant, and could include screening rules and procedures as well. And where nonprocreative issues are at stake, or where the public participation is sought that might harm others, including the resulting children, the surrogates and the donors, banning altogether might be permissible. Examples, I believe, would include commercial surrogate motherhood, selling of human embryos, and experimentation on human embryos.

So in conclusion and summary then, Mr. Chairman, I believe the regulation of the new reproductive technologies is after all primarily a matter for the individual states. Just as they regulate adoptions, custody, marriage, medical licensing and medical practice, it seems most reasonable for the individual states to regulate the practice of the new reproductive technologies at least insofar as they are seen as medical procedures and are performed by physicians.

Regulations in the area of quality control and monitoring, safety, record keeping and inspection and licensing, consent, the identification and obligations of mothers and fathers, requirements for donor screening, are all well within the traditional state police powers and activities and regulations in these areas would not raise any major social policy or constitutional implications.

Federal activity in the new reproductive technologies, on the other hand, has been restricted to setting up and financing various national commissions, which we've heard a lot of this morning, and groups of various kinds to study the scientific, legal and ethical issues involved in these practices, and to make recommendations as to what actions various private and governmental organizations should take.

The Federal government could, however, become more involved in its own traditional areas such as the regulation of interstate commerce, forbidding the sale of human tissues, regulating false and deceptive advertising and promulgating rules for human research, without raising any major Federal implications. Major Federal involvement, however, seems reasonable only when related directly or indirectly to Federal financing of these technologies.

Government has only the most limited role in preventing contraception and prohibiting abortion, but has a potentially much higher role in the new reproductive technologies—not only protecting the interests of the adults to quality services and informed consent, but also taking reasonable steps to protect the interests of future children that are created by these methods. Regulations that are firmly grounded in reasonable steps to protect these children are legitimate and likely to enjoy broad societal support.

Thank you.

[Prepared statement of George J. Annas, J.D., M.P.H., follows:]

PREPARED STATEMENT OF GEORGE J. ANNAS, J.D., M.P.H., UTLEY PROFESSOR OF HEALTH LAW, BOSTON UNIVERSITY SCHOOLS OF MEDICINE AND PUBLIC HEALTH, BOSTON, MA

Mr. Chairman, members of the Committee, thank you for inviting me to address the legal and ethical aspects involved in regulating the new reproductive technologies. Most of my work in this area has been scholarly commentary, but I have also represented infertility organizations and specialists over the years, as well as infertile couples who have used the techniques we are discussing today. I am also a member of the board of directors of RESOLVE, the nation's leading support organization for infertility, although my testimony today represents my personal views.

I was especially pleased to be invited to testify because I believe the public debate over these issues has been characterized primarily by emotionalism and dogmatism, with little attempt to place the issues in a broader context, little attempt to make necessary distinctions, and almost no consideration of the best interests of the resulting children. It is the purpose of my brief remarks to suggest a more coherent framework for analysis.

The New Reproductive Technologies

Each of the new reproductive technologies could be viewed individually. It is, however, more analytically fruitful to identify and explore their common characteristics relevant to public policy, since other methods will no doubt be developed, and permutations of existing methods can also be used. Thus, unless we are to have a separate policy for each method (an unlikely and ultimately unproductive response - like having a separate public policy for each form of treatment for cancer), we will have to identify the characteristics that these methods share that make regulation important and useful.

Table One summarizes the social policy issues raised by each of the techniques, and impressionistically assigns weights to each issue to give an overall view of the relative social utility of regulating each method, and the generic importance of each social policy issue. A more detailed discussion is contained in Appendix A, which contains the chapter on "Noncoital Reproduction" from Elias & Annas, Reproductive Genetics and the Law (1987). As can be seen from this table, GIFT and IVF are the least socially problematic of the procedures; with SET and the use of frozen embryos presenting the most difficult social policy issues.

TABLE I

Index of Relative Importance of Societal Issues in Noncoital Reproduction*

ISSUES+	AID	IVF	SET	GIFT	SURROG MOTHER	FROZEN EMBRYO
Potential for noninfertility use	2	2	2	2	2	3
Protection of embryo	0	3	3	0	0	3
Identification of mother	0	0	3	0	3	3
Identification of father	2	0	2	0	2	3
Donor screening	2	0	2	0	2	2
Donor anonymity	2	0	2	0	2	2
Opportunities for Commercialization	1	1	3	1	3	3
Total:	9	6	17	3	14	19

* 1, indicates of societal concern, but not sufficient to require uniform guidelines; 2, of sufficient societal concern to require uniform guidelines; and 3, of sufficient societal concern to justify discouraging or perhaps prohibiting the procedure altogether if reasonable uniform guidelines cannot be agreed on and enforced.

+ Definitions: potential for noninfertility use: Use of the technology to gain access to the embryo for research or genetic manipulation; avoidance of pregnancy for "convenience" of the genetic mother; use of technique for eugenic purposes. Protection of the embryo: Exposure of the embryo to the potentially hostile laboratory environment; research that would not directly benefit that embryo; use that would devalue the embryo and human life. Identification of mother: Difficulty in distinguishing between the genetic mother and gestational mother and determining who will be legally identified as the presumptive rearing mother. Identification of father: Difficulty in distinguishing between the genetic father and the rearing father and determining who has legal responsibility for rearing the child. Donor screening: Requirements for gamete donors and method of ensuring compliance. Donor anonymity: What records should be kept, by whom, and how access can be gained to them by the child. Opportunities for commercialization: Buying and selling gametes, embryos, or children and the implications for society.

The first, and paramount issue social policy issue raised by this group of new reproductive technologies is their medical nature and the implied medical indications and "potential for noninfertility use." The issue of protecting the extracorporeal embryo applies only when such an embryo is produced, and this will occur in IVF and SET. Issues of parental identification, donor screening, and donor anonymity arise when more individuals than the married couple themselves are involved in producing gametes for the resulting child: AID and SET. Of course, should we employ donor gametes in either GIFT or IVF, the same screening, record keeping and parental identification issues would be raised by these techniques as well.

When reviewing the legal options for regulation on both the state and federal level, it will be useful to keep in mind the "pressure points" at which regulation can be brought to bear. In general, these will be: control of medical practice; control of human experimentation; defining the presumptive rearing father and mother; granting legal protection to the extracorporeal human embryo; legal provisions for donor screening and record confidentiality; regulation of commerce in gametes and embryos; and attaching conditions to the delivery of medical services that are paid for by government programs. Protecting the interests of children, for example, will require detailed record-keeping concerning their genetic parents.

Overview of Regulatory Activity to Date

It is fair to say that the federal government has not engaged in any regulatory activity in this area. On the other hand, the federal government has over the last thirteen years formed three important commissions that have made recommendations regarding the new reproductive technologies: The National Commission, the Ethics Advisory Board, and the President's Commission on Bioethics; and is in the process of forming another (the Congressional Biomedical Ethics Board).

States have been a bit more active in AID (more than half of the states have laws making the husband of the impregnated woman the child's father for all legal purposes so long as he has consented to AID), and a number of states have regulations related to fetal research. But no states have specific statutes on IVF, SET or GIFT. Since the regulation of medical practice is primarily a state function, regulation of the actual delivery of these technologies is almost always primarily a task for the individual states.

States could also regulate the new reproductive technologies indirectly by statutorily defining which woman, as between a gestational, genetic, and planned-rearing mother would have presumptive rearing rights and obligations with respect to the child. I believe *states should enact statutes that clearly define the gestational mother* (i.e., the woman who gives birth to the child) *as the irrebutably presumed mother for all legal purposes*. This is because of her gestational contribution to the child, and the fact that she will definitely be present at the birth, be easily and certainly identifiable, and available to care for the child. Such a law would have the effect of helping to legitimate and protect children born from SET, but would give so-called surrogate mothers the right to retain their children even in the face of a prior contractual agreement to give it up for adoption or to relinquish parental rights in the child after birth. She could do either, but only *after* the child was born and the standard waiting period for adoption or relinquishment of parental rights had expired. This presumption would also operate in the case of ovum donation in a manner analogous to AID (sperm donation): the gestational, not the genetic mother, would be the presumptive rearing mother.

Overview of Federal Authority

In the area of health care in general, and the new reproductive technologies in particular, Congress can act in areas where the federal government has indirect authority: primarily taxation and spending, and interstate commerce.

The most important area in which Congress has used its power to spend to adopt regulations related to the new reproductive technologies has been in the area of research on human subjects, and most physicians and institutions engaged in research on these technologies must follow federal requirements for such research.

Regulation of interstate commerce can involve a ban on the sale of an article. Congress has indicated its willingness to ban the purchase and sale of human body parts, and could certainly ban the interstate sale of human embryos (and sperm and ova as well). In 1984, for example, Congress passed the "National Organ Transplant Act". While most of the Act is aimed at promoting organ transplantation in the United States, Title III is directed exclusively toward prohibiting organ purchases. It's operative section reads:

> It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

For the purpose of this act, "human organ" is defined to mean "the human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin..." Violation carries a five year maximum prison sentence, and a $50,000 fine. Congress should amend this statute to include human embryos among the items it is unlawful to sell. The purpose would be to protect children by preventing them from being viewed as and treated as commodities.

Constitutional Limits on Regulation

The right to privacy encompasses decisions to use contraceptives, not to be sterilized involuntarily (except, perhaps when it is the least drastic alternative and in a person's best interest), and to use contraceptions and to obtain an abortion (i.e., a right not to beget or bear a child). The question is whether this right will be expanded to include an affirmative right to actually parent a child, will be stable, or will be contracted.

In June, 1986, the U.S. Supreme Court decided an exceptionally controversial case dealing with the issue of whether or not a state could constitutionally make sodomy committed by two adult males in the bedroom of a private home a crime (Bowers v. Hardwick, 106 S. Ct. 2841). The Court concluded that there is "no fundamental right to engage in homosexual sodomy." Fundamental rights not readily identifiable in the Constitution's text would be found only if (1) they were fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist without them"; or (2) they are "deeply rooted in this Nation's history and tradition." In terms of the "right to privacy," the court limited its application to a "connection between family, marriage, [and] procreation..."

In addition to upholding laws against sodomy, the Court indicated that laws against "adultery, incest and other sexual crime" would also be constitutional. As to whether or not a legislative finding that certain conduct is immoral is a sufficient basis for outlawing it, the court concluded that it was, noting that "the law is constantly based on notions or morality...and majority sentiments about the morality of homosexuality" are sufficient justification to outlaw this behavior.

This was a 5-4 decision, with a concurring opinion of Justice Powell and a strong dissent by Justice Blackmun. Blackmun argued that the Court had fundamentally misconstrued and defined too narrowly the "right to privacy," which should be seen as embodying "the moral factor that a person belongs to himself and not others nor to society as a whole":

> We protect the decision whether to have a child because parenthood alters so dramatically an individual's self-definition, not because of demographic considerations or the Bible's command to be fruitful and multiply. (emphasis added)

With respect to the new reproductive technologies, we need to examine the underlying values at stake in procreative privacy to delineate the scope of this right. These include self-identify, self-expression, freedom of association, freedom to make decisions that drastically affect one's identify, and rights to have intimate relationships with a view toward producing a child. Although the Court is badly split on the reach of privacy outside of a heterosexual union, there is no such split concerning privacy within a heterosexual union when that union is aimed at procreation.

All members of the Court would thus likely conclude that IVF, SET, and GIFT, if conducted within the context of marriage at least (and probably if done in any "stable" heterosexual relationship) are to be viewed as within the ambit of the "right to privacy." Accordingly, only laws similar to those endorsed by the Supreme Court to regulate previable abortions (i.e., those aimed primarily at restricting performance to physicians, monitoring the safety and efficacy of the procedures, and insuring informed consent) could be used to regulate these activities. AID regulations could be stricter, since they involve another participant - the sperm donor - and could include screening rules and procedures as well. Where nonprocreation issues are at stake, or where public participation is sought that might harm others, including the resulting children, banning altogether might be permissible. Examples would include commercial surrogate motherhood, selling human embryos, and experimentation on human embryos. The view of one religion alone (e.g., the Catholic Church) that any or all of these techniques are "illicit" would, in itself, be an insufficient rationale to ban them.

Conclusion

Regulation of the new reproductive technologies is primarily a matter for the individual states. Just as they have regulated adoption, custody, marriage, medical licensing and medical practice, it seems most reasonable for the states to regulate the practice of new reproductive technologies insofar as they are seen as medical procedures and performed by physicians. Regulations in the area of quality control and monitoring, safety, record keeping, inspection and licensing, consent, the identification and obligations of mothers and fathers, and requirements for donor screening, are all well within the traditional state activities and regulation in these areas and would not raise any major social policy implications. In extreme cases, such as banning the sale of human embryos or on having experimentation with human embryos, statutes would have to be carefully drawn (so as not to be voided for vagueness) and based on a reasonable state policy designed to protect the common good and preventing children from being treated like commodities.

Federal activity in the new reproductive technologies, on the other hand, has been restricted to setting up and financing national commissions and groups of various kinds to study the scientific, legal and ethical issues involved in these practices, and to make recommendations on what actions various private and governmental organizations should take. The federal government could, however, become involved in its own "traditional" areas, such as regulation of interstate commerce, forbidding the sale of human tissue, regulating "false and deceptive" advertising, and promulgating rules for human research, without any major implications. Major federal involvement, however, seems reasonable only when related directly or indirectly to federal financing of these technologies.

Government has only the most limited role in preventing contraconception and prohibiting abortion (mainly health and safety of the adult participants), but has a potentially much higher role in the new reproductive technologies: not only protecting the interests of the adults to quality services and informed consent, but also taking reasonable steps to protect the interests of future children that are "created" by these methods. Regulations that are firmly grounded in reasonable steps to protect these children is legitimate, and likely to enjoy broad societal support.

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THE RIGHTS OF HOSPITAL PATIENTS (Avon, 1975) (author)

GENETICS AND THE LAW (Plenum, 1976); GENETICS AND THE LAW II (Plenum, 1980); GENETICS AND THE LAW III (Plenum, 1985) (co-editor)

INFORMED CONSENT TO HUMAN EXPERIMENTATION: THE SUBJECT'S DILEMMA (Ballinger, 1977) (co-author)

THE RIGHTS OF DOCTORS, NURSES AND ALLIED PROFESSIONALS (Avon and Ballinger, 1981) (co-author)

REPRODUCTIVE GENETICS AND THE LAW (Year Book, 1987) (co-author)

Articles:

Author of approximately 200 articles and columns on health law, including *The Patient Rights Advocate* (Vanderbilt Law Review, 1974); *Medical Malpractice Litigation under National Health Insurance: Essential or Expendable*?, (1976 Duke Law Journal 1353-1373); *Allocation of Artificial Hearts in the Year 2002* (American Journal of Law and Medicine, 1977); *Fathers Anonymous: Beyond the Best Interests of the Sperm Donor* (Family Law Quarterly, 1980); *Competence to Refuse Medical Treatment: Autonomy v. Paternalism* (Toledo Law Review, 1984); *Death and the Magic Machine: Informed Consent to the Artificial Heart* (W. New England Law Review, 1987)

APPENDIX A

Reproductive Genetics and the Law

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Chapter 9

Noncoital Reproduction

Now that 1984 has come and gone, Huxley's vision of our future in *Brave New World* looms larger than Orwell's. Huxley envisioned the abolition of parenthood and the family that would take place with the full cooperation of society as it attempted to improve on natural reproduction.* We are on our way. The last few years have witnessed scientific and societal developments in noncoital human reproduction and corresponding steps to redefine parenthood and family relationships. On the scientific side, we witnessed the first birth from surrogate embryo transfer (SET)[1] and the first birth from a frozen embryo. On the societal side, there have been major reports by government-appointed panels on noncoital reproduction in the United Kingdom (the Warnock Report),[2] Australia (the Waller Report from Vic-

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*In Orwell's world of *1984*, AID (artificial insemination by donor) was mandatory, and sexual pleasure and the family were destroyed to help maintain the tension necessary in a society dedicated to perpetual warfare. In Aldous Huxley's *Brave New World*, the family was also destroyed; but he portrayed a society controlled not by fear but by gratification and reinforcement. Abolition of the family was followed by complete sexual freedom; but reproduction was handled by the state, in "hatcheries" in which embryos were produced and monitored in an artificial environment: "[Of] course, they didn't content themselves with merely hatching our embryos: any cow could do that. 'We also predestine and condition. We decant our babies as socialized human beings, as Alphas or Epsilons, as future sewage workers or. . .' He was going to say 'future World controllers,' but correcting himself, said 'future Directors of Hatcheries,' instead." In both futuristic scenarios, the critical elements of governmental success were the separation of sex from reproduction, and the abolition of the family. In Margaret Atwood's futuristic *The Handmaid's Tale*, the role of sex is reduced to stylized ritual, with forced surrogacy; insemination is done coitally while the surrogate lies between the legs of the infertile wife. One surrogate describes her station: "We are two-legged wombs, that's all; sacred vessels, ambulatory chalices."

toria),[3] and Canada (Ontario),[4] and Congressional hearings on the subject in the United States.[5]

Techniques for noncoital reproduction close a circle opened with the introduction of effective contraception that made sex without reproduction dependable. Society seems as supportive of the new techniques for reproduction without sex as it was of contraception, but we seem more anxious about the implications these techniques raise and consequently more interested in public regulation of them. As with in vitro fertilization (IVF) and surrogate motherhood, the major justification offered for using these new techniques has been the resulting infants. Their pictures have appeared in newspapers and magazines around the world, and *People* magazine even named the world's first IVF child, Louise Brown, one of the ten most prominent people of the decade, one who dominated it "by simply being."[6]

Ambivalence is nonetheless apparent in the language used to describe the new techniques in various countries. In Australia, they are sometimes referred to as methods of "abnormal" reproduction; in England as "unnatural" reproduction, and in the United States the preferred term is "artificial" reproduction. We use the term "noncoital" since it is the most descriptive and the least value-laden. With developments occurring rapidly in noncoital reproduction, especially in North America, Australia, and Europe, it seems prudent to reflect on the societal issues raised by these techniques and to assess their future. The policy problem is how to deal effectively "with a series of sequential challenges" to current clinical practices.[7] It will often be critical to make distinctions, usually previously irrelevant, between the genetic, gestational, and rearing parents when sorting out individual rights and responsibilities.[8] Indeed, it is now possible for a child to have five "parents": a genetic and rearing father, and a genetic, gestational, and rearing mother.[9]

We believe it is more fruitful to explore the generic issues posed by methods of noncoital reproduction than to examine the methods themselves separately. While it would be possible to explore all of the potential methods of noncoital reproduction, including artificial insemination by husband (AIH), ovum donation, and the various possible combinations, such as IVF, SET, and frozen embryos with implantation in a surrogate mother (so-called "full surrogacy"), in this chapter we concentrate on the methods that present society with the most difficult generic problems. For example, AIH poses no problems of identifying the rearing parents or any issues regarding the sperm donor and so is *much* less problematic than artificial insemination by donor (AID) itself. Fifty years ago, about the time of the publication of *Brave New World*, AIH children were commonly referred to as "Test Tube Babies."[10] At that time, the notion of asking a physician to inject "strange semen" (AID) was described as "outlandish" and lacking in "tact, decency, and moral feeling."[10] Society has obviously come a long way attitudinally in the past half-century. Similarly, the problems in ovum donation are so analogous to those involved in AID that a separate consideration would be redundant. Issues involved in the myriad of possible combinations can likewise be addressed by looking at the individual methods themselves. Issues raised by cloning and ectogenesis, which are not so remote as to be relegated to science fiction, are analogous to those involving use of frozen embryos.

None of these technologies and techniques are neutral. Their very existence forces us to decide to use them or not, and also creates a new potential burden for the infertile, "the burden of not trying hard enough."[11] Noncoital reproduction forces us to confront issues of lineage, legitimacy, parenthood, family, and identity. These techniques not only change how humans can reproduce, but they also threaten to change how we think about human reproduction, and perhaps how we think about humanness itself.

In reviewing the social policy issues raised by these methods, we have found it useful to construct Table 9–1 in which we list the most important policy issues raised by these techniques, and in the cells we assign values to their importance. The values assigned represent our view of the normative importance of each issue in the context of a specific noncoital method of reproduction. We do not contend that these values are unambiguous or incontrovertible, but we believe the attempt to quantify provides a useful impressionistic model to compare and contrast the relative societal importance of the issues raised by each technique. Even a cursory examination of Table 9–1 explains, for example, why we begin our discussion with IVF rather than AID: IVF poses far fewer societal issues. As the President's Commission properly cautioned, the state of the law regarding AID is "chaotic" and by using it as the paradigm for other methods of noncoital reproduction, like IVF and embryo transfer (ET), we risk repeating "the chaos surrounding artificial insemination . . . with egg donors and borrowed wombs."[12]

OVERVIEW OF SOCIETAL ISSUES

In Vitro Fertilization (IVF)

In vitro fertilization followed by embryo transfer requires highly sophisticated biomedical technology to obtain one or more ovum, fertilize them in a Petri dish, and transfer the embryo to the woman's uterus. Nonetheless, when confined to married couples (using an ovum of the wife and the sperm of the husband), IVF actually presents far fewer societal problems than AID, because the genetic, gestational, and rearing parents are identical.

TABLE 9–1.

Index of Relative Importance of Societal Issues in Noncoital Reproduction*†

ISSUES‡	AID§	SURROGATE MOTHER	IVF§	SET§	FROZEN EMBRYO
Potential for noninfertility use	2	2	2	2	3
Protection of embryo	0	0	3	3	3
Identification of mother	0	3	0	3	3
Identification of father	2	2	0	2	3
Donor screening	2	2	0	2	2
Donor anonymity	2	2	0	2	2
Opportunities for commercialization	1	3	0	3	3
Total	**9**	**14**	**5**	**17**	**19**

*(From Elias S, Annas GJ. Social policy considerations in noncoital reproduction. *JAMA* 1986; 255:62. Courtesy of *JAMA*, copyright 1986, American Medical Association.)

†1 indicates of societal concern, but not sufficient to require uniform guidelines; 2, of sufficient societal concern to require uniform guidelines; and 3, of sufficient societal concern to justify discouraging or perhaps prohibiting the procedure altogether if reasonable uniform guidelines cannot be agreed on and enforced.

‡Definitions: *Potential for noninfertility use:* Use of the technology to gain access to the embryo for research or genetic manipulation; avoidance of pregnancy for "convenience" of the genetic mother; use of technique for eugenic purposes. *Protection of the embryo:* Exposure of the embryo to the potentially hostile laboratory environment; research that would not directly benefit that embryo; use that would devalue the embryo and human life. *Identification of mother:* Difficulty in distinguishing between the genetic mother and gestational mother and determining who will be legally identified as the presumptive rearing mother. *Identification of father:* Difficulty in distinguishing between the genetic father and the rearing father and determining who has legal responsibility for rearing the child. *Donor screening:* Requirements for gamete donors and method of ensuring compliance. *Donor anonymity:* What records should be kept, by whom, and how access can be gained to them by the child. *Opportunities for commercialization:* Buying and selling gametes, embryos, or children and the implications for society.

§AID indicates artificial insemination by donor; IVF, in vitro fertilization; and SET, surrogate embryo transfer.

Accordingly, IVF rather than AID should be used as the starting point for any analysis of the policy implications of noncoital reproduction. As noted in Table 9–1, IVF raises two major societal issues: indications and protection of the embryo.*

Medically, IVF has been developed primarily to permit married couples with infertility due to the wife's irreparable fallopian tube disease to have children. In vitro fertilization may also prove useful in cases in which the husband has a low sperm motility. A more controversial indication is "idiopathic infertility" in which evaluation of the couple (i.e., history, physical examination, laparoscopy, testing of fallopian tube patency, endocrine profiles, semen analysis, etc.) reveals no cause for infertility. An estimated 10% to 15% of infertile couples fall into this category. Possible explanations include immunologic factors, undiagnosed abnormalities of oocyte or sperm transport, undefined physical or chemical barriers preventing sperm penetration of the ovum, genetic abnormalities, and unrecognized uterine abnormalities. Virtually all cases of infertility, exclusive of intractable anovulation and those women without a uterus, are potential medical candidates for IVF.[13]

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*In vitro fertilization also raises the more universal issues of resource allocation and informed consent. Is the procedure worth offering at all if its success rate cannot be dramatically increased from its current level of less than 20%, and how should candidates for the procedure be counseled concerning its extremely high probability of failure?

Legally and ethically, who should be considered a candidate for IVF? For example, should single women with fallopian tube disease be considered candidates for the procedure? This question should probably be answered the same as, "Should single women be considered candidates for AID," i.e., should medical technology be used to assist in the creation of single-parent families? The US Ethics Advisory Board (EAB) recommended that IVF be restricted to married couples.[14] In Australia, it has been recommended (even more restrictively) that, while it is acceptable to favor married couples who have had children during the experimentation phase, after IVF becomes established procedure, priority should be given to those married couples who have not had any children. This issue must be resolved on a broader base then medical practice because the family issues involved are not medical. In addition to life-style and marital status, financial status plays a large role. Is infertility a disease, and should its treatment be covered by medical insurance?

Because of the extracorporeal fertilization of the ovum and temporary in vitro development of the embryo, even more controversial new issues are presented: defining the steps that should be taken to protect the embryo and determining the extent to which experimental protocols are applicable to clinical use of IVF. All members of the US Ethics Advisory Board,[14] the Warnock Commission,[3] and the Waller Commission[4] agreed that the human embryo is worthy of respect and legal protection and cannot be treated like a hamster or other experimental animal.* The groups also agreed that no research should be permitted after 14 days following laboratory fertilization, but the reasons for this cutoff date varied, including that 14 days is the time normally associated with implantation, when individual development of the embryo begins, and marks the beginning of the formation of the primitive streak. Until the basis of the 14-day limit is more clearly articulated and publicly accepted, it cannot serve as a legitimate regulatory boundary. Are we concerned with what the embryo *is,* what it looks like, or what it feels? Or are we concerned with what it *will be,* or what it will never have a chance to be, or with what it will look like or feel? Or is the focus of our concern something else entirely?

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*The Waller Commission approved embryo research "in order that the success rate of the clinical IVF program be improved . . ." It also permitted embryos to develop no more than 14 days because this is the end of the stage of implantation, and "after this stage the primitive streak is formed, and differentiation of the embryo is clearly evident." The committee approved this by a 7–2 vote; but by the same 7–2 margin voted that no human embryo be brought into existence solely to be used in research because it was morally unacceptable to use a "genetically unique human entity" solely as a "means to an end." The United Kingdom's Warnock committee was split. All agreed with the US EAB's approach that the "embryo of the human species should be afforded some protection in law." The 14-day limit was also adopted, but on the basis that "day 15 marks the time of the formation of the primitive streak, and the beginning of individual development of the embryo." The committee did recommend that it be permissible to create embryos for research purposes alone, but the vote was very close (9–7). Even so, the Warnock committee unanimously condemned the routine testing of drugs on human embryos because of the large numbers of embryos this would require. The Ontario Commission adopted the 14-day limitation, recognizing that it is "arbitrary" but "could easily be amended" if "the state of medical knowledge at some future date indicates that it is inappropriate."

Artificial Insemination by Donor (AID)

Artificial insemination by donor has become widely accepted, with an estimated 250,000 AID children in the United States alone.[15] But familiarity has not resolved the societal problems raised by this technique. About half the states have enacted laws making the consenting husband of the woman inseminated the lawful father of the resulting legitimate child, but half have not. Controversy continues regarding the methods of selecting and screening donors, the use of single women as recipients, the types of records kept, and what information about their genetic father, if any, the children should be able to obtain. Nonetheless, AID is the accepted paradigm for all other methods of noncoital reproduction as evidenced by Commissions like Warnock and Waller.[3,4] It may be an unworkable paradigm, however, because it potentially places the private contractual agreement among the participants regarding parental rights and responsibilities above the best interests of the child, and because it raises a series of societal issues that remain unresolved.[15] Indeed, by beginning one's analysis with AID and assuming that deciding about parenthood by contract is socially accepted as currently practiced, we ignore the relevance of legitimacy, lineage, and individual identity tied up in kinship, and thus bypass fundamental questions about the definition of fatherhood and its role in the family and the life of the child.[16] If, on the other hand, legitimacy is no longer a major social issue in the United States, and lineage is much more important in a country like England where hereditary titles might be at stake,† Alexander Pope's question, "To Whom Related, and By Whom Begot?" may be less relevant today.

Probably the most interesting and problematic societal issue still unresolved in AID is donor screening. In AID, this is a two-step process: a general pool of candidates is selected (e.g., medical students), and then some additional screening is done to ensure that the potential donor does not have specific conditions, such as sexually transmissible diseases. Neither of the two steps in the process has been either well thought out or standardized. As to the initial screen, two points should be made. The first is that the term "donor" is descriptive only from a biologic perspective. From a legal and ethical perspective, virtually all sperm suppliers are actually "sperm vendors," since they sell their sperm for money.[15] While this distinction may seem one without a difference, it has practical consequences for both physicians and sperm suppliers. Primarily, the sperm vendor should not sign a consent form (since he is *not* a patient, and is not consenting to the physician treating him), but a contract in which he agrees to deliver his sperm for pay. The elements of the agreement can be tailor-made to the setting and should spell out the vendor's obligations in terms of his own physical and genetic health, including accurate family history, the quality of the semen he has agreed to produce, and a waiver of any rights to any child resulting from the insemination.

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†In England, the issue of hereditary titles is very much alive, as the Royal College of Obstetricians and Gynaecologists noted in their IVF Report.[16] The RCOG quoted with apparent approval a December 20, 1982, publication of the Law Commission on Family Law and Illegitimacy: "The Commission was advised that children born following AID should not succeed to a title of honor, either that of the husband of the inseminated woman or that of the donor of the sperm."

Second, far too little attention has been devoted to identifying the pool from which sperm vendors are drawn. The vast majority of physicians use medical students and house officers. It is often alleged that these individuals are the most convenient because they are always around. But the janitorial staff or the hospital security staff would qualify equally well on convenience grounds. What is really occurring is that physicians are making eugenic decisions, selecting what they consider "superior" genes for AID. In general, they have chosen to reproduce themselves, as sociobiologists would probably predict. Although physicians may believe that society needs more individuals with the attributes of physicians, it is unlikely that society as a whole does. Lawyers would likely select law students; geneticists, graduate students in genetics; military officers, students in military academies, and so forth.[16] The point is not trivial. Selecting donors in this manner is in the best interests of physicians, not infertile couples. Since the couple is not usually permitted to select the donor, physicians should develop guidelines that permit donation by a random sample of the population.

Actual screening of the donor and the donor's sperm demands the development of uniform professional standards that do not exist, and a reasonable enforcement mechanism to ensure that they are followed. For example, in the case of human immune virus (HIV), it seems reasonable to exclude men who engage in high risk activities from participation as sperm donors. It may also be reasonable to test the donors for HIV antibodies, freeze the sperm, and retest the donor 6 to 12 months later. Only if both tests are negative can one conclude that the sperm cannot transmit HIV to the potential child.[17]

Surrogate Mothers

Relying not on new medical technology but on lawyers as brokers, surrogate motherhood has received increased media attention in the past few years. This method employs a fertile woman who is artificially inseminated with the sperm of the husband of an infertile woman. The surrogate agrees to bear a child for the infertile couple and turn it over to them upon birth, either by giving the child up for adoption or by relinquishing her parental rights and obligations.

This is a much more socially problematic practice than either AID or IVF because it raises new issues of maternity (identity of rearing mother) and the commercialization of motherhood, as well as the older AID question of paternity, donor screening, and donor anonymity. The maternity issue, i.e., identifying the woman with the legal right and obligation to rear the child, involves the surrogate's ability to change her mind and keep the child, and perhaps even successfully sue the sperm donor for child support, as well as the child's interest in knowing its genetic lineage and having its gestational mother care for it. The commercialism issue involves paying the surrogate mother for her "services," and whether or not such payment is properly seen as compensation for gestational services, or as "baby buying," an activity prohibited in almost all states.[13] The Ontario Law Reform Commission has recommended that surrogate contracts should be specifically enforceable and argues persuasively that this is required to protect the parties.[4] Nevertheless, because of the trauma of removing a newborn from its gestational mother against her will, we do not believe contracts with surrogates should be specifically enforceable against the surrogate.* A suit against her for money damages for the emotional harm suffered by the contracting couple should she change her mind and keep her child might, however, be successful. The lack of legislative or judicial recognition of the surrogate mother contract has been one of the major obstacles to increasing the popularity of this method. We believe that the potential problems, as

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*Following an almost five-year battle between the Attorney General and a surrogate parenting corporation, the Kentucky Supreme Court ruled in 1986 that Kentucky's baby-selling statute did not prohibit surrogate motherhood arrangements so long as the price was agreed upon *before* conception, and the surrogate mother retained the right to cancel the contract up to the point of relinquishing her parental rights after the birth of the child (*Surrogate Parenting Associates v. Kentucky*, 704 S.W.2d 209 [1986]). We think this case was wrongly decided since we believe that the essence of surrogate motherhood is not new science, as the majority of the court argued, but old commercialism.[18] On the other hand, treating the gestational mother's right to rear the child as inalienable prior to birth seems reasonable because of her greater physical and psychological bonding to the child. Because of the lack of data, the Ethics Committee of the American Fertility Society has recommended that surrogate motherhood only be pursued as a "clinical experiment."[19] This however, seems to place too much emphasis on surrogacy as a "medical solution for infertility,"[19] rather than on surrogacy as a contractual, commercial enterprise.

illustrated in the 1987 case of Mary Beth Whitehead, are so critical that this inhibition should remain. Our guess is that commercial surrogacy will wither if legislation to regulate and legitimate it is not enacted. Such legislation would amount to a societal approval of this method and likely encourage imitation.

The arguments in favor of commercial surrogacy are that it promotes reproductive autonomy for those who could not otherwise reproduce, is "womb rental" rather than baby selling, and is unlike payment for adoption because the deal is made prior to pregnancy, and the resulting child is genetically linked to one of the adopting (contracting) parents (the father). We believe, nonetheless, that only women desperate for money would produce children for pay, and that commercialism in babies degrades both mother and child. Although we generally do not believe in outlawing specific methods of human reproduction, we oppose positive societal encouragement of commercial surrogacy.

SURROGATE EMBRYO TRANSFER: A SOCIAL POLICY CASE STUDY

The most recent development in noncoital reproduction is surrogate embryo transfer (SET), and even though it has not proved popular, this technique provides a useful model to examine the major policy implications of all forms of noncoital reproduction. Sometimes described as "uterine lavage for preembryo transfer,"[19] SET involves the nonsurgical recovery of an embryo by uterine lavage from a surrogate who has been artificially fertilized with the sperm of an infertile woman's husband, and the subsequent transfer of that embryo into the uterus of the infertile woman.[1] Almost all of the issues of IVF and surrogate mother combined are raised by SET. We say "almost all" because the bonding and likelihood of the embryo donor refusing to undergo the lavage procedure and retaining the pregnancy (should one result) is much less likely than the risk that a surrogate mother who carries the child to term will opt to keep it.[20] Surrogate embryo transfer directly presents all of the other issues: indications, protection of the embryo, maternity, paternity, donor screening and anonymity, and commercialization (see Table 9–1, p. 225).

Indications

Surrogate embryo transfer has been introduced using the same indication as that used for the initial IVF trials: infertility in married couples due to irreparable fallopian tube disease.* This raises at least two questions: in what sense is infertility a disease, and in what sense is use of SET (or any other method of noncoital reproduction) a therapeutic treatment for infertility? A similar question can, of course, be asked of the most popular form of birth control, sterilization; is sterilization a treatment for fertility? Diseases are, to a large extent, social constructs, and it seems fair to conclude that both physicians and society have defined involuntary infertility as a disease. Although it is a condition from which individuals suffer, it has generally been treated only in the context of a marital relationship. The "treatment" may be more accurately described as a "service," since the disease or disability is not treated or cured (as it would be in a fallopian tube transplant), but the condition is technologically bypassed. The indications for such noncoital reproduction services must be defined on a broader base than medical practice, since the value of the traditional family unit and the relationship of childbearing to child rearing are not medical issues. Proponents of using new reproductive techniques based on contracts among adults rather than on marriage and family relationships have argued that the traditional family unit is giving way to multiple models and that our practices should mirror reality. They in effect justify noncoital reproduction outside the traditional family on the basis that the traditional family unit is breaking up. But, is this move to multiple family models to be fostered, or should society attempt to reverse it? We currently have no social policy on "families." Nonetheless, it seems disingenuous to argue on the one hand that the primary justification for noncoital reproduction is the anguish an infertile married couple suffers because of the inability to have a "traditional family," and then use the breakup of the traditional family unit itself as the primary justification for unmarried individuals to have access to these techniques.

Protecting the Embryo: Parental Rights and Duties

We can assume that the embryo, once transferred into an otherwise infertile woman, is highly regarded by both the woman and her husband. In IVF there would be no embryo without the in vitro beginnings and development. But SET actually jeopardizes the well-being or survival of an existing embryo by removing it from its "safe harbor," the donor's uterus. The justification is that the embryo donor had no intention of having the child herself, and the removal is just part of a larger procedure to attempt a pregnancy that otherwise would not have occurred. This simply restates the argument that "all we are doing is making babies," a laudable objective, but not an end that justifies any means. For example, the desire to have a child does not justify kidnapping another's child, or forcibly removing an embryo from a "donor" who has changed her mind. It may also not justify putting a healthy embryo at risk, any more than we would be justified in exposing the embryo to teratogens prior to implantation.

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*In addition, SET could be used when the woman has no ovaries (i.e., after surgical removal) or abnormal ovaries (e.g., streak gonads in 45,X individuals).

Who should have the authority to make decisions concerning the extracorporeal embryo in SET? The understanding is that the embryo, once removed from the donor, will be transferred to the infertile wife. However, even with such a contract, the "donor" maintains the ability to continue the pregnancy. Once the embryo is transferred, the recipient contributes the gestational site and assumes the risks of pregnancy, and she should therefore have the final decision-making authority over the embryo. Because of her greater contribution and risk and to provide certainty of identity and responsibility necessary to protect both mother and child at the time of birth, the gestational mother (rather than the genetic mother) should be deemed the child's legal mother for all purposes.[13, 18] Her husband should likewise be deemed the child's legal father.

The period of embryonic life that has received the greatest attention has been its brief extracorporeal existence. This in vitro period exposes the embryo to an artificial and potentially teratogenic or lethal environment and provides an opportunity for genetic engineering. Both authority and responsibility during this period are undefined. Although ethically bound to follow through with transfer, the physician could destroy the embryo or transfer it to a woman other than the sperm donor's wife. Legal control over the extracorporeal embryo should be vested in the sperm donor who has contributed genetically to it and who has the most interest in seeing it successfully implanted as his future child. The ovum donor relinquishes all rights and responsibilities to the embryo when it is voluntarily flushed from her uterus. Furthermore, since the *only* justification for SET is to enable the married woman to bear a child that was genetically her husband's, the sperm donor and the physician with custody of the embryo should have authority only to do those things that would reasonably promote this objective. Consequently neither would have the authority to "volunteer" the embryo for research or donate it to another woman.

Donor Selection

Donor selection has always been the most discussed issue in AID, and remains a central issue in all forms of noncoital reproduction (except IVF with married couples). When donors are selected on the basis of some particular desirable trait or set of traits, eugenic decisions are being made. The question is how such decisions should be made. A Nobel Prize sperm bank has already been established, and a counterpart panel of ovum donors can be envisioned, as can catalogs of frozen embryos. Since most desirable genetic traits are polygenic/multifactorial, however, such banks are unlikely to ever be very popular or effective in producing individual traits in offspring, at least until the technology exists to clone specific embryos.

How should the women who will be used as donors in SET be selected? Fertility is obviously important, but should they already have had children? Should they be married, single, or divorced? What should their economic and social status be? What medical and genetic characteristics should rule them out as donors? What types of genetic and psychological screening tests should be performed and who should perform them? What kinds of agreements regarding preinsemination intercourse retained pregnancies and abortion should they be asked to make prior to the procedure? What relationship, if any, should the donor have with the child? None of these questions have self-evident answers, and all should be resolved before SET (or any similar technique) is made widely available.

Donor Anonymity and Record Keeping

The basic thrust of current AID policy is to protect the sperm donor from any claims the resulting child might have on him.[15] This protection has been almost obsessional, and in the process the interests of the child are usually given a lower priority. In both AID and SET, two basic issues are raised from the child's perspective: (1) Does a child have a significant interest in having only two unambiguously identified parents? and (2) Does the child have a significant interest in knowing how it was conceived, implanted, and gestated? If the answer to the first is yes, we may wish to devise a system in which at least one, but only one, mother and one father can possibly be identified for each child. If we cannot ensure such unique identification, it would seem that the child should have access to identifiable information about his genetic mother in the SET setting, and his genetic father in the AID setting. We admit that this is a difficult issue; however, since such information could be kept secret only by purposeful deception, since the child has no voice in the matter, and since it may be an extremely important psychological (and possibly medical or genetic) issue to the child seeking information about his genetic heritage, records should be kept of all births in a way that they can be matched with donors.[15] We think medical professionals should maintain these records. But if they refuse, legislation may be needed to require their deposit with a court of relevant jurisdiction. The donor can effectively waive any right to access to such records, but no one should be able to effectively waive the child's future access to genetic, medical, and perhaps even personal information about the donor.

These records could have two "levels": level one would be medical and genetic history that did not identify the donor; level two would contain the donor's actual identity. Access to level one information should be guaranteed. Access to level two should be possible if the child can demonstrate a "need to know." The objection that such a practice might make AID impossible because donors would not be willing to be identified seems misplaced. The only survey of donors we have been able to locate found that 60% would donate even if their identity was made known to the resulting children,[21] and a 1985 Swedish law requiring that children be able to learn the identity of their AID father at the age of 18 only temporarily discouraged sperm "donation."[21]

FROZEN EMBRYOS

It seems reasonable to freeze the embryo in SET if the planned recipient becomes ill or has an accident immediately prior to the planned transfer; or in IVF to preserve multiple embryos for use in subsequent cycles. In IVF this eliminates the need for repeated ovum retrievals should the initial pregnancy attempt fail, allows greater convenience in determining time of transfer, and may even increase the efficacy of the procedure.[23] Freezing embryos, however, forces us to reexamine all of the issues raised by noncoital reproduction (see Table 9–1). This is not because of freezing *per se* (assuming it can be accomplished without damage to the embryo) but because freezing raises the possibility of transferring the embryo to a multitude of potential donees over an extended period of time.

The recent case of a wealthy US couple who died leaving two frozen embryos in Australia caused an international debate about their legal status and what should be done with them, including their possible implantation in a surrogate.[3] Other potential problems include confusion of parental identity because the embryo may not be genetically related to either of its rearing parents; frozen embryos could be implanted in surrogates for convenience; embryos could be maintained for generations (raising the possibility of a woman giving birth to her genetic aunt or uncle); siblings could be born from different sets of parents; embryos could be removed using the SET embryo removal procedure from any woman, and (when the technology is available) karyotyped, examined for nonchromosomal genetic defects, and discarded, treated, frozen for reimplantation during the woman's next cycle or at some future time, donated to another woman, or sold.

The possibility of frozen embryo banks, in which embryos are produced to order by matching the sperm and ovum of "ideal" types and then sold to parents for genetic or eugenic purposes, also raises concerns of commercialism. Even if we accept paying a surrogate mother for the "work" of pregnancy, we could still reject traffic in embryos since in this case there is absolutely no ambiguity about what is being bought or sold. We may even wish to go further and require procedures similar to adoption when frozen embryos are used. This amounts to "prenatal adoption" when neither prospective parent has contributed genetically to the embryo, although such a procedural requirement seems extreme and confuses notions of "what will be" with those of "what is."

Before launching any regulatory initiative in the United States, it is useful to review recent action in the United Kingdom, Australia, and Canada on these issues.

COMMISSION REPORTS

United Kingdom

In July of 1984, the government-sponsored Warnock Commission, named after its chairperson, Dame Mary Warnock, issued a report that made 63 specific recommendations: 33 involving a proposed licensing board to regulate clinical services and research; 7 involving the National Health Service's infertility program; and 23 involving new British laws, including naming of 7 new crimes.[1] The Warnock Commission, for example, proposed outlawing all aspects of surrogate motherhood, including both for profit and nonprofit organizations, and professional activities designed to "knowingly assist in the establishment of a surrogate pregnancy." The British Government has already legislated to ban commercial surrogacy, and the other proposals are under debate.

The commission also expressed concern about payment to sperm donors, ovum donors, and embryo donors, but adopted a much more cautious approach to this problem. It recommended legislation be "enacted to ensure there is no right of ownership in a human embryo," but stopped short of suggesting that the purchase and sale of gametes be outlawed, apparently because it believed such a move would threaten the sperm supply for AID. Accordingly, its official recommendation was that "*Unauthorized* [by the state licensing authority] sale or purchase of human gametes or embryos should be made a criminal offence."[2] The Commission did not suggest what guidelines the licensing commission should adopt, or if it should become involved in price-setting for gametes and embryos. This matter awaits resolution.

Australia

The Australian Commission for the State of Victoria was, if anything, more aggressive than its British counterpart. Under the direction of Law

Professor Louis Waller, the Commission issued reports in August 1983 and August 1984.[3] These reports made a total of 54 recommendations, many of which were written into laws dealing with the Status of Children (passed May 15, 1984), and Infertility (passed Nov 2, 1984). These laws continue the Australian ban on sales of human tissues, including sperm, ova, and embryos; and outlaw cloning, fertilization of a human ovum with an animal gamete, use of children's gametes, mixing of sperm in AID, and all commercial forms of surrogate motherhood.

The infertility legislation also sets up a system of state regulation for AID, IVF, freezing and experimenting on embryos, counseling of participants, and required record keeping. In addition, a standing committee is created to study and report to the government about new developments in this field. One of the issues not yet considered in Australia by either the government or the Waller Commission, for example, is SET (the Warnock Commission recommended that SET "not be used at the present time"). The Status of Children legislation creates an irrebuttable presumption that the woman in whose womb a child gestates is the mother of that child.

On the issue that has received the most press coverage, the disposition of frozen embryos, the Warnock and Waller Commissions diverged considerably. The Waller Commission recommended that in the absence of specific instructions from the gamete donors, frozen embryos in storage should be destroyed upon the death of the gamete donors. The Warnock Commission, on the other hand, recommended that their fate be determined by the storage facility, in effect treating them like unclaimed baggage. While there are problems with both "solutions," the Waller approach seems more reasonable, since the interests of the gamete donors are superior to those of the storage facility.

Canada

The Ontario Law Reform Commission's Report was prepared following Warnock and Waller and relies heavily on both of them. The Commission came up with 67 specific recommendations, generally favoring artificial reproduction "where medically necessary to circumvent the effects of infertility and genetic impairment."[4] As this statement implies, the Commission recommended that these procedures be legislatively defined as the "practice of medicine." Access to them should be restricted to "stable single women and to stable men and stable women in stable marital or nonmarital unions." Gamete banks that buy and sell sperm, ova, and embryos were permitted to operate under state license and to extract payment by users "to defray reasonable costs, and perhaps, to provide a reasonable profit."[4]

The most notable divergence is in the area of surrogate motherhood.

The Commission recommended a legislatively established regulatory scheme to govern surrogate mother arrangements. All agreements must be in writing and have the prior approval of the Family Court, which will "assess the suitability of the prospective parents for participation in such an arrangement," including the couple's medical need for using it. The court would also assess the "suitability of a prospective surrogate mother," including her physical and mental health, marital status, and likely impact on her children of the arrangement. The most controversial recommendation is:

> A child born pursuant to an approved surrogate motherhood arrangement should be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parents. In addition, where the court is satisfied that the surrogate mother intends to refuse to surrender the child upon birth, it should be empowered, prior to the birth of the child, to make an order for transfer of custody upon birth.[4]

While payment is permitted, no payment shall be made without prior court approval. Finally, the Commission recommends that five years after its regulatory scheme has been implemented, "a review of all aspects should be undertaken by an appropriate governmental body." The surrogate motherhood enforcement provision, which makes a gestational mother's rearing rights alienable before birth, could face serious constitutional problems relating to violation of privacy and personhood in the United States.

The United States

The United States had a National Commission to examine fetal experimentation in the mid-1970s, an Ethics Advisory Board (EAB) in the Department of Health, Education and Welfare (now the Department of Health and Human Services), and most recently, a Presidential Commission on Bioethics. The first Commission proposed strict regulations on fetal experimentation,[24] the EAB recommended that research on IVF go forward under similarly regulated conditions,[14] and the President's Commission endorsed the views of the EAB on IVF, and spent little time on other methods of noncoital reproduction. The Commission did, however, recommend that AID donors should be screened for their "genetic history," that records of source and sample should be kept, and that steps should be taken to ensure that the confidentiality of the donor is protected to the "greatest extent possible."[25] Federal law requires EAB approval for any federally funded embryo research, so the demise of the EAB in 1979 has meant no federal funding, and a de facto moratorium on open embryo research in the United States since then. We currently have a Working Group on Gene

Therapy (a subcommittee of NIH's Recombinant DNA Advisory Committee), but no national commission comparable to Warnock, Waller, or Ontario to develop public policy.[26] One should be established.[5, 22, 27] Like Australia, but unlike the United Kingdom, our laws relating to parenthood and reproduction are primarily state laws. Accordingly, the debate about the appropriate legislative responses to the challenges of these noncoital methods of reproduction is already under way in many state capitals.

PROPOSED LEGISLATIVE ACTION

Since they have not been adequately debated in public, it is premature to attempt to answer all of the issues raised by these techniques, but it is foolish not to act on those that can be relatively easily resolved. Of the three issues that generate the most concern (see Table 9–1), two are capable of legislative solution now: identification of the mother and commercialization.

Identification of the Mother

Identification of the mother gets a higher "point value" in Table 9–1 than identifying the father because the mother plays a much more significant role in the gestation and birth of the child than the father. Unlike the father, for example, the gestational mother will always be present and easily identifiable at the moment of birth. The social policy issue is whether the genetic or gestational mother will be *legally* presumed to have the right and responsibility to rear the child. This situation will arise in SET, in the use of surrogate mothers generally, and in the use of donor (usually frozen) embryos. We believe that it is critical for the protection of both the mother and child that the legal mother (i.e., the woman with rearing rights and responsibilities) be identifiable at the time of birth. This confirms the child's maternal legitimacy and provides the child with a caretaker and a person legally responsible for the child's welfare, and able to consent to its treatment. It also protects the gestational mother from exploitation. Given the need for certainty and the greater biologic and psychological investment of the gestational mother in the child, we think the Victorian Parliament was correct in codifying the traditional legal presumption: the gestational mother should be irrebuttably presumed to be the child's legal mother for all purposes. She may later agree to give the child up for adoption or otherwise relinquish her parental rights and responsibilities, but that decision is one she will make as the child's legal mother, and the child's legal mother will *always* be readily identifiable. A state statute codifying this traditional legal presumption, and making it irrebuttable, would be protective of both mother and child.*

Commercialism

The social policy goal is to prevent children from being viewed as commodities that can be purchased, sold, returned, and exchanged, because this view will lead to attitudes and practices detrimental to the well-being of children as well as to a reconceptualization of human life and the value of human life. It would seem that surrogate motherhood has enough potential legal and personal problems surrounding it that it is unlikely to survive as a viable option unless laws are passed that encourage it by clarifying its legal status. Surrogacy can be viewed as a voluntary degradation of oneself because it treats one's body as a mere incubator, and degradation is no more acceptable because it is voluntary.[16] Money, of course, makes it worse, be-

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*Only one case has reached even a lower court on this subject, and that case was dealt with extremely superficially and can hardly be termed "the law." The case (*Smith & Smith v. Jones & Jones*, 85-532014 DZ, Detroit, MI, 3d Dist. March 15, 1986) involved an infertile couple (because the wife lacked a uterus) who contracted to have her ovum fertilized with her husband's sperm, and the resulting embryo implanted in a married surrogate who would gestate it, and then present the child to its genetic parents. Thus we had a case of "full surrogacy." A few weeks prior to the birth, lawyers for the two couples went to court to ask Judge Marianne O. Battani to declare the genetic parents the legal parents so, among other things, their names would appear on the birth certificate. The judge agreed, mainly we think because no one was appointed to represent the child, and no legal arguments were presented in opposition to the petition. The judge based her ruling primarily on her view that the state's paternity statute should apply equally to maternity. Unfortunately, as the judge appears to have realized by describing the gestational or "birthing mother" as "a human incubator for this embryo to develop," the opinion demotes pregnant women to the status of incubators. The decision also makes identification of the child's legal mother *at birth impossible*. The judge dealt with this by ordering that HLA tissue-typing confirm "maternity," but understood that this would not be possible for at least a few days (perhaps more) after birth. While many will applaud the judge for putting contracts before biology, the judge was not faced with the case her opinion raises: what if *neither* the genetic nor the gestational mother contracted for the child, but rather a third party who had no ovaries had contracted for the baby? Does it make any sense at all to say that *neither* the genetic nor the gestational mother is the mother, i.e., that biology has nothing to do with motherhood, only rearing rights that are the subject of a contract and a monetary exchange?[18] In view of the dubiousness of this result, we also find it unprofessional and distasteful that on the basis of this opinion, the lawyer for the couple sent a solicitation letter to obstetricians which said, among other things, that this decision "could have an overwhelming impact on your medical practice . . . [because the legal drawbacks to full surrogacy] have been virtually eliminated by Judge Battani's exciting and far-reaching opinion . . . I have available surrogates ready for immediate selection for any couple you may refer to me. If your practice does not include all of the medical procedures described, I have qualified physicians willing to undertake such procedures" [undated form letter from Noel P. Keane].

cause the motivation becomes entirely material, and a price is put on the product, i.e., the child. Although we oppose commercial surrogacy, we do not believe the law should prohibit a friend or relative to act as a surrogate out of love or compassion. This gets the state too closely involved in human reproduction, and a reasonable argument can be made that although giving a "gift" still treats the child as a thing in some ways, in the absence of a monetary exchange, the child is not treated as a commodity but remains a "priceless gift," the giving of which, like the giving of blood, is a gesture of love and altruism.[28] On the other hand, new problems of multiple known parents will have to be dealt with by the participants. Similarly, it may be reasonable to permit embryo donation, but commerce in embryos seems wrong. There is an almost universal consensus that kidneys should not be bought and sold, and this has recently been codified in federal law.[29, 30] The arguments against the sale of human embryos are even more compelling. A commercial market in prefabricated, selected embryos would encourage us to view embryos as commodities that are simply means to the ends we design (with or without regulation), rather than as human entities without a market price. British law professor Ian Kennedy has argued that we know intuitively that a human embryo is more valuable than a hamster or other experimental animal, and that is why we have trouble permitting experiments on human embryos.[31] Likewise, we know intuitively that the human embryo is more valuable than a kidney and of much more symbolic importance regarding human life; that is why we believe embryos should not be the subject of commerce.

Embryos, like babies from surrogate mothers, will be bought or sold, if at all, on the belief that they will produce a healthy child, and possibly one of a certain physical type, IQ, stature, and so forth. When the child is not born as warranted or guaranteed, what remedies will the buyer have against the seller? Accept, reject, return for a refund or another "item"? The problem with commerce in human embryos is that the sale of human embryos can become confused with the sale of human children.[27] Accordingly, it seems reasonable to outlaw the sale of human embryos. Sale of sperm and ova does not present the same problem, but the Warnock and Waller Commissions may well be on the right track in discouraging commerce in gametes and in limiting payment to out-of-pocket and medical expenses. It may be time to experiment with other methods to recruit sperm donors in the United States besides money. For example, as in France, couples who use AID could be required or requested to find one or more of their friends to act as sperm donors for other couples.

Forbidding the sale of human embryos does not improperly interfere with an individual's constitutional right to procreate (assuming *arguendo* that this right includes the right to use noncoital techniques), any more than legally limiting an individual to one spouse, and making it illegal to purchase either another spouse or a license for polygamy.†

CONCLUSION

No commission (or any two authors) can solve all of the social policy issues raised by noncoital reproduction. Nonetheless, previous work and this discussion demonstrate both that noncoital reproduction decisions cannot survive solely in the private domain of infertility specialists, and that the private contract paradigm used in AID is outdated and inadequate to protect children, parents, the family, and social values. We will need new guidelines and even some new laws. These guidelines can and should be developed by professional associations with public participation, and a reasonable start has been made.[19, 33, 34] Both the courts and legislatures are likely to look with favor upon professional guidelines in this area that have been well thought-out, and private practitioners should welcome reasonable and responsible guidance. In formulating more comprehensive guidelines, we suggest the following as useful foundations:

1. To protect the interests of resulting children and the legitimacy of noncoital reproduction, primary consideration should always be given to the welfare and "best interests" of the potential child, rather than to the donors, the infertile couple, or the physician or clinic.[13–15, 25–29]

2. To protect the interests of resulting children, complete and accurate records should be kept of all participants, including donors, so that donors can be matched with offspring. These records should be kept confidential, but in a manner that makes future access by the child possible if this is determined to be in the child's best interests.[15, 25]

†It also seems wrong for medical professionals involved in developing new techniques of noncoital human reproduction to patent the *process* they develop. This is because patenting places them in a conflict of interest position in regard to candidly reporting on their research and could also restrict independent, unbiased evaluation by other investigators. But since other motives, like pursuit of the Nobel prize or tenure, might as easily contaminate research as the profit motive, we must condemn patenting noncoital processes on other grounds. We think the most persuasive is the argument that the government should not be involved in controlling or supervising, directly through its police powers, or indirectly through its patenting powers, the process of human reproduction. This is because the subject matter of the patent does not lend itself to patent infringement enforcement without potentially unbearable privacy violations.[32] The American Fertility Society has reached the same conclusion, but for different reasons.[19]

3. To protect all participants, uniform and complete standards for donor selection and screening, including genetic screening, should be developed and made public.[14, 15, 19, 38, 40]

Action on three levels is warranted: (1) a model state law designed to clearly define the gestational mother as the irrebuttably presumed legal mother for all purposes, and to outlaw the sale of human embryos should be enacted;* (2) professional organizations, with significant public participation, should develop and promulgate guidelines for sound clinical practice; and (3) a national body of experts in law, public policy, science, medicine, and ethics should be established to debate and monitor developments in this area and report annually to Congress and the individual states on the desirability of regulation and legislation.

At all levels, the primary focus of social policy formation should be on protecting the best interests of the planned-for children, even if their protection sometimes comes at the expense of some infertile couples and some gamete donors or vendors. This general policy is one that helps protect basic societal values and can provide noncoital reproduction itself with societal legitimacy.

Twenty-five years after he wrote *Brave New World*, Aldous Huxley opined, "That we are being propelled in the direction of *Brave New World* is obvious. But no less obvious is the fact that we can, if we so desire, refuse to cooperate with the blind forces that are propelling us."[41] More than another quarter of a century later, we still enjoy the opportunity to participate in shaping our reproductive future, but the opportunity will not last forever.

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*Florida has already enacted a statute that provides "no person shall knowingly advertise or offer to purchase or sell, or purchase, sell or otherwise transfer, any human embryo for valuable consideration" (Fla. Stat. Ann. sec. 873.05[1]).

Chapter 9: Noncoital Reproduction

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STATEMENT OF LORI B. ANDREWS, J.D., RESEARCH FELLOW, AMERICAN BAR FOUNDATION, CHICAGO, IL

Ms. Andrews. Thank you. The Baby M Case has prompted a vast societal discussion and has raised a number of legitimate concerns about the new reproductive technologies. Today I'd like to address those concerns and speak about the role of Federal and State law and how it should develop based on what we know about alternative reproduction. In doing so I'll pay particular attention to the effects of the technologies on families and on children.

One lesson learned during the course of the Baby M case was that despite reservations that many people have about various aspects of reproductive technologies, the majority of people do not believe that surrogate motherhood should be banned, nor do I feel that such a ban would be constitutional.

A Newsweek poll during the Baby M trial found that the majority of people think that surrogacy for medical indications should be allowed and that the contract should be enforced. Similarly, a study by the Child Welfare League of America found that 64 percent of child welfare agencies favored regulation of surrogacy with only 24 percent favoring prohibition and 10 percent favoring no regulation.

There are also similar surveys about artificial insemination by donor and in vitro fertilization, which both garner the approval of the majority of the public. There is a strong societal belief in the importance of having the opportunity to be a parent and a recognition that for some couples the only way to become a parent is to use reproductive technology.

The families created through alternative reproduction are particularly strong ones. For example, there has been only a 1 percent divorce rate among the couples who have given birth to children using artificial insemination by donors as compared to the 49 percent divorce rate for the population as a whole.

The shared societal value regarding the importance of families, the fact that these families seem to be doing all right, along with the constitutional protection for the right to privacy should caution legislators that they should tread carefully before adopting laws that restrict or prohibit the use of reproductive technologies. Laws affecting alternative reproduction should only be adopted if they further a compelling governmental interest in the least restrictive manner possible.

I see the role of the government in this area as having two components. The first is to help assure that people have the opportunity to create families and in that respect I'd like to echo what Dr. Chavkin was describing earlier in that I think there is a leadership role for the Federal government in funding research in the prevention and treatment of infertility. The Federal government could also enforce and even develop more laws to protect against environmental hazards and workplace hazards that present a threat to people's fertility.

The second component is to protect the physical and psychological well-being of the participants in alternative reproduction and, there, the primary concern should be the child.

Some opponents of the procedures, including at least one witness in the Baby M case, publicly stated that alternative reproduction should not be allowed because it is like adoption and adoption creates damaged children. Such a statement not only stigmatizes existing adopted children but misrepresents the facts. Large scale studies have found that there is little difference in adjustment and achievement between adopted and nonadopted children. A child born after surrogacy or donor insemination should fare at least as well as an adopted child, particularly since the child will be reared by a biological parent and his or her spouse, not a stranger, as in traditional adoption situations.

In the one area of alternative reproduction where there have been studies, that with respect to artificial insemination by donor, the research shows that the children born through these techniques are thriving physically, emotionally and intellectually.

The children born through alternative reproduction also deserve to have a clear indication of who their legal parents are. Professor Annas has suggested that the legal parent needs to be the gestational mother because gestation is the only key to legal parenthood. I think that's rather silly, because generations of men have been able to be recognized as parents without having to give birth, so I don't think legal parenthood should hinge on who gives birth. And traditionally, legal parenthood has been determined by statutory enactments. For example, in Arkansas there is now currently a law which says that if a couple contracts with an unmarried surrogate, that couple are the legal parents of the child and not the surrogate.

When physicians first offered artificial insemination by donor, they advised couples to adopt the child, since the child had no biological relation to the husband. However, the state laws regulating donor insemination have rejected the adoption model. Instead, 30 states by statute declare that a man who consents to the insemination of his wife with donor sperm is the legal father. Thus, the preconception intent of the parties (the intent of the donor to relinquish parental rights and the intent of the couple to accept them) govern who the legal parents are after the child is born.

In the case of surrogate motherhood where the woman provides a gamete and gestates the child as well, the suggestion has again been made that the adoption model should apply. However, the reasons for certain protections in the adoption situation do not seem to be present in the surrogate situation.

Let me say that whenever there is a legal situation in which parental rights are transferred, the law requires that at a certain point in time that decision be final. For example, some states in their adoption law suggest that six months after birth the adoption is final. It's easy to imagine a situation in which a mother seven months after the birth or seven years after the birth may want that child back. Such a mother may present as compelling a picture as Mary Beth Whitehead did in her love for the child. Nevertheless, we do not reopen adoptions once the time has passed unless there is proof of coercion or fraud.

I believe that with respect to surrogacy, the point in time in which the decision should be final should be before the birth rather than after the birth. This difference in policy is appropriate due to a difference in circumstances. The reason we give an already pregnant woman a chance to change her mind after the child is born is because we want to assure that the woman has a chance to make an informed, unpressured decision. In contrast, a surrogate can make her decision to give up a child in advance of conception at a time in which she can make an informed reflection about whether she wants to bear a child for another couple. She can take as long as she wants to decide whether or not she would be a surrogate. She is not faced with the fait accompli of an existing pregnancy about which she must make a difficult choice. Instead, the potential surrogate has a range of choices and alternatives to pregnancy for how she will spend her time.

In addition, the potential effect on the child is much different when there is a change of mind by a surrogate as opposed to a biological mother who has promised to give the child to strangers in an adoption situation. The strangers in the adoption situation have no legal link to the child. So the child immediately becomes part of a biological mother's family with no period of insecurity. In contrast, in surrogacy, the man wishing to rear her child is the child's biological father. As the Kentucky Supreme Court has pointed out, the man already has a legal relationship to the child. The surrogate's mind change thrusts the infant into legal uncertainty requiring a lengthy court battle to determine who will be given the opportunity to rear the child. In order to avoid that possibility, it is important to uphold the preconception agreement of the parties to determine who the legal parents are. In most instances, 99 percent of the time, this will be exactly what all the parties want and it will be helpful to have legal sanctions for it.

There may be some surrogates, however, who do change their minds and are emotionally harmed by this approach. In my opinion, however, it is more appropriate to put the risk of harm on the few women who change their minds after signing a contract rather than have the risk borne by all the children born of surrogates who would be in legal limbo if surrogacy custody arrangements were not thoroughly enforceable.

If we are going to uphold the contracts in alternative reproduction, as pending laws in nine states would do, we do need legal protection to assure that participation is voluntary and informed.

In the Baby M case there was evidence of an advance psychological assessment of Mrs. Whitehead that she would have difficulty giving up the child. She may not have been an appropriate candidate for surrogacy. Some of the pending state laws have excellent provisions for helping assure that the women fully understand what surrogacy entails and for assuring that they enter into it voluntarily. A New York bill provides that the surrogate is entitled to independent representation by counsel. It provides that the court must approve the contract in advance of conception and assure the surrogate has given voluntary informed consent. If a woman such as Mary Beth Whitehead, who had doubts about her decision before impregnation, had come before the Court, it is unlikely that the court would have approved the contract. Instead, the court would have required Mrs. Whitehead to do some deep soul searching, which might have deterred her from being a surrogate altogether.

Even with adequate information being provided to potential surrogates, there is a concern that in our society's social and economic reality, some women, such as women on welfare or in dire financial need, will turn to surrogacy out of necessity rather than true choice. In most surrogate situations, this is not the case. However, to protect the few potential surrogates who might get involved out of necessity, the Federal government definitely should act. There should be vigilant effort to assure that women have equal access to the labor market and that there are sufficient social services so that poor women with children do not feel that they must create and sell another child to provide for their existing children.

If these injustices were alleviated, then all the women acting as surrogates would be doing so out of true choice.

I'd like to address Professor Annas' concern about what the constitutional rights are of a surrogate. Surrogates definitely have a constitutional right not to participate in these arrangements. No one is saying that we should be able to force women to do these things or take their children away. And Professor Annas has painted an intimidating picture that we might have police coming and taking a woman's baby from her. But we do that all the time now in terms of judicial enforcement of custody agreements when a couple divorces. The Federal government has enacted a Parental Kidnapping Act so that once there has been a determination of who the legal parents are, anyone else who is holding that child (even if they have a biological link to the child) is subject to the possibility of State intervention to take the child away.

The Baby M case struck a very deep chord in many of us because it raised concerns about many social issues, such as economic inequalities, differential treatment of the sexes, changing nature of the family and so forth. I hope the legacy of the case will not just be hearings like those today about alternative reproduction, but attempts to deal with the broader social concerns that the case revealed.

Thank you.

[The prepared statement of Lori B. Andrews, J.D., follows:]

PREPARED STATEMENT BY LORI B. ANDREWS, J.D., RESEARCH FELLOW, AMERICAN BAR FOUNDATION, CHICAGO, IL

Earlier this year, the attention of people throughout this country — and the world — was focused on a single surrogate mother case taking place in a New Jersey courtroom. This case has prompted vast societal discussion about surrogacy and other reproductive technologies and has raised a number of legitimate concerns about the procedures. This morning I'd like to address those concerns and discuss how federal and state law should develop based on what we know about alternative reproduction.

The Infertility Issue Should Be Put into a Larger Social Context

The experience of childbearing and childrearing is of importance to many people's lives. Currently, there are a number of barriers to achieving that experience — such as infertility, deficient or absent prenatal care, or deficient or absent infant care. Any policies for dealing with the treatment of infertility should also consider the prevention of infertility, fetal demise, stillbirth and infant mortality.

One in six individuals of childbearing age in the United States is infertile. Other individuals, while they can conceive a pregnancy may not be able to bring it to term. In addition, infant mortality in the United States is high, with 10.9 deaths per 1000 live birth per year, higher than the 10.3 in Germany, 10.2 in the United Kingdom, 9.0 in France, 8.5 in Canada, and 6.2 in Japan.[1] Nutritional deficiencies among pregnant women are implicated in problems in pregnancy and breastfeeding.[2] There is thus a need to redefine "infertility" to encompass not only physical barriers to fertility, but also social ones and to extend the term "infertility" to cover women whose children do not live through infancy.

There has been insufficient attention paid to developing and offering preventive measures in health rather than high tech solutions.[3] Federal and state statutes have sometimes been adopted to help redress that imbalance by specifically providing for financial and other encouragement of preventive health care services.[4] Similar provisions are appropriate with respect to infertility in its broadest sense. In addition, the federal government could take a leadership role in funding research in the prevention and treatment of infertility. The federal government could also enforce (and develop) laws to protect against environmental hazards and workplace hazards that present a threat to people's fertility.[5]

Reproductive Technologies Should Not Be Banned

The Baby M case raised questions about whether certain routes to parenthood — such as artificial insemination by donor or surrogate motherhood — should be closed off. Some opponents to the procedures, including at least one witness in the Baby M case, publicly stated that alternative reproduction should not be allowed because it is like adoption and adoption creates "damaged" children.[6] Such a statement not only stigmatizes existing adopted children, but misrepresents the facts. Large-scale studies have found that there is little difference in adjustment or achievement between adopted and nonadopted children.[7] A child born after surrogacy or donor insemination should fare at least as well as an adopted child, particularly since the child will be reared by a biological parent and his or her spouse (not a stranger as in traditional adoption).

There was an additional concern put forward as a reason to ban surrogacy — the concern that it was akin to babyselling. Babyselling is altogether different from paying a surrogate pursuant to a preconception contract. Babyselling is prohibited in our society because children need a secure family life and should not have to worry that they will be sold and wrenched from their existing family. When a surrogate is paid, the resulting child is never in a state of insecurity. From the moment of birth, from the moment that child is a person, she is under the care of her biological father and his wife. There is no psychological stress to that child or any other existing child that he or she may someday be sold. (This is in sharp contrast to a policy that would allow the sale of babies or children).

Similarly, paying a surrogate a fee is unlike paying an already pregnant woman for her child. Since the decision is made before the pregnancy ensues and the arrangement is entered into with the specific intention of relinquishing the child, the surrogate is less likely than an already-pregnant woman to be coerced into giving up a child she wishes to keep. In fact, forbidding payment may actually lead to more coercion since the only way an infertile woman could then obtain a surrogate would be put to pressure on a friend or relative to be a surrogate. Arms-length transactions with paid surrogates who are represented by attorneys are less likely to result in coercion than pressure by a friend or relative.

Surrogate motherhood is not like black market adoption. Since the child will be raised by the biological father and his wife, it is more likely that the rearing parents will have a greater sense of responsibility for the child than if the child were turned over to a stranger. Historically, with respect to natural reproduction, a biological bond was considered a sufficient reason to trust the parents responsibility for the child.

Regulation of Surrogate Motherhood Should be Sensitive to the Strong Societal Value Put on Reproduction

One lesson learned during the course of the Baby M case was that, despite the reservations that many people have about various aspects of surrogacy, the majority of people do not believe that surrogate motherhood should be banned (nor do I feel that such a ban would be constitutional). A Newsweek poll during the Baby M trial found that the majority of people think that surrogacy for medical indications should be allowed and that the contract should be enforced.[8] This does not mean that they themselves would necessarily choose to be a surrogate or use a surrogate. Rather, they feel that this is an option that should be available to people who wish to undertake it. This echoes earlier surveys of the public and child welfare agencies. For example, a study by the Child Welfare League of America found that 64% of child welfare agencies favored regulation of surrogacy, with only 24% favoring prohibition and 10% favoring no regulation.

There are similar surveys about artificial insemination by donor and in vitro fertilization, which both garner the approval of the majority of the public.[9] These statistics, along with the intense sympathy that many people felt for both biological parents seeking custody of Baby M, point to the strong societal belief in the importance of having the opportunity to be a parent. This shared societal value, along with the constitutional protection of the right to privacy,[10] should caution legislators that they should tread carefully before adopting laws that restrict or prohibit the use of reproductive technologies. Such laws should only be adopted if they further a compelling state interest in the least restrictive manner possible.

The interests that are compelling at this point are the need to assure that participation in alternative reproduction is informed and voluntary, that the bodily integrity of the participants is protected, and that legal parenthood of the resulting child is clearly spelled out in law.

Statutes Governing Informed Consent Should Be Adopted

Society allows competent adults to take risks (for example, trying an experimental procedure, engaging in a risky sports activity, or joining the armed services), even though an individual's decision might be motivated by a range of influences (for example, economic, social, or religious influences). In the medical realm, the individual is allowed to make risky choices so long as she has given voluntary, informed consent. Users of reproductive technologies, donors, and surrogates all need adequate factual information about the risks of alternative reproduction in order to make adequate assessments about whether they should participate in the procedures.

Informed consent of the patient is legally required by case law in all states before a medical procedure is undertaken. The legal doctrine requries that physicians disclose to patients, among other things, the nature of a proposed procedure, its risks and benefits, and the available alternatives.[11] Patients have a right to refuse medical intervention. However, physicians do not have a good track record for obtaining informed consent generally,[12] nor with respect to alternative reproduction. For example, infertility clinics generally do not reveal to potential patients the great variation that exists with respect to success rates. In a survey of 53 in vitro clinics,[13] only 38 had successfully achieved the birth of a child.[14] When artificial insemination by donor is used, the average length of time from artificial insemination to pregnancy ranges from 2.5 months at some clinics to 9.5 months at others. This points to the need for physicians to provide information, not about the overall success rate in the field, but of the particular qualifications and track record of that particular physician and clinic.

A law should be adopted requiring a health care provider to tell the potential user of alternative reproduction about the nature of the process, its risks and benefits, and any alternative techniques that could be used to create a child. A donor or surrogate should be given similar information. The law should also require the physician to provide his or her success rate with the procedure as well as the overall success rate of the particular clinic. In addition, it should require that the participants be given information about the availability of counseling, mutual aid groups, and other resources for making alternative reproduction a more physically and psychologically satisfying experience. To the extent that people want to add protections to assure that the surrogate has given voluntary, informed consent, it might be appropriate to adopt a law requiring separate legal representation of the surrogate and/or approval of the surrogate contract by a judge in advance of the insemination.

No one wants to see surrogates hurt by these arrangements, and a particular lesson that we learned from the Baby M case is that we should try harder to find surrogates who will be benefitted, rather than harmed by their decisions to bear a child for an infertile couple. In the Baby M case, there was evidence of an advance psychological assessment that Mrs. Whitehead would have difficulty giving up the child. She may not have been an appropriate candidate for surrogacy. A pending New York bill has excellent provisions for assuring that women fully understand what surrogacy entails and for assuring that they enter into it voluntarily. The bill provides that the surrogate is entitled to independent representation by counsel. It provides that a court must approve the contract in advance of conception and assure that the surrogate has given voluntary, informed consent. If a woman such as Mary Beth Whitehead who had doubts about her decisions before impregnation had come before the court, it is unlikely that the court would have approved the contract. Instead, the court would have required Mrs. Whitehead to do some deep soul-searching, which might have deterred her from being a surrogate altogether.[15]

Even with adequate information provided to potential surrogates, there is a concern that in our society's social and economic reality, some women — such as women on welfare and in dire financial need -- will turn to surrogacy out of necessity, rather than true choice. In most surrogate situations this is not the case. However, to protect the few potential surrogates who might get involved due to necessity, the federal government definitely should act. There should be vigilant efforts to assure that women have equal access to the labor market and there are sufficient social services so that poor women with children do not feel that they must create and sell another child just to provide for their existing children. If these injustices were alleviated, then all the women acting as surrogates would be doing so out of a true choice. For the time being, however, it would be hypocritical of the federal government to ban surrogacy or to ban paid surrogacy when the government itself has created a situation in which women may be compelled to turn to surrogacy, since the government has not adequately enforced the employment discrimination laws and has underfunded social service programs.

There is an additional reason to be suspicious of a federal law banning paid surrogacy. An historical analysis of laws aimed at keeping women from particular jobs in order to protect their reproductive capacity reveals that the laws did not really protect women; instead, they merely closed off certain jobs to women, generally higher paying jobs no more dangerous than the ones they were permitted to take. Janet Gallager, for example, notes that "Women's unequal treatment before the law has often — much more often than not — been justified by claims that it's necessary to protect women and their special function as childbearers. But defining and protecting women in terms of reproductive capacity has been the basis for women's inequality and lack of economic and political power."[16]

The Law Should Protect the Bodily Integrity of the Participants in Alternative Reproduction

Besides the need for laws to assure voluntary, informed consent, attention must be paid to the protection of bodily integrity. Of all the concerns for bodily integrity raised by alternative reproduction, concerns for the surrogate's autonomy in reproductive decisions loom the largest. A surrogate has contracted to bear a child for someone else. After its birth, she has promised to turn the infant over for rearing by its genetic father and his partner. Such an arrangement may be viewed by the intended parents as giving them a right to control the surrogate's activities during pregnancy. Some surrogate contracts claim to give the couple the right to force the surrogate to follow doctors' orders, to undergo amniocentesis and have an abortion (or not have an abortion) based on their desires. A law proposed in Michigan a few years ago would have prohibited a surrogate from smoking or drinking during pregnancy. Such contracts and laws overlook the fact that the surrogate has a right to bodily integrity. It is inappropriate for the government to set standards on women's behavior during pregnancy. Such standards should not be part of a statute covering surrogates. While private arrangements between the surrogate and the couple may specify restrictions or suggest a medical regimen, they should not be legislatively sanctioned or enforced through the court system.

Legal Parenthood

When physicians first offered artificial insemination by donor to the wives of infertile men, they advised the husband to adopt the resulting child (since he had no biological relation to the child). However, the state laws regulating artificial insemination by donor have rejected the adoption model. Instead, they rely on an informed consent approach. In 29 states, by statute, the husband of the sperm recipient is the legal father if he consents to be the legal father in advance of the insemination.[17] Thus, the pre-conception intent of the parties governs who are the legal parents after the child is born.

Similarly, in the first court case regarding the use of a surrogate carrier (a woman who gestated the embryo of a couple), the pre-conception intent was allowed to govern who the legal parents were after birth. In that case, the intended mother underwent in vitro fertilization of her egg with her husband's sperm to create an embryo, but because she had previously undergone a hysterectomy for a ruptured uterus, the couple's embryo was implanted into a surrogate carrier. The court granted the genetic parents the right to have their names put on the birth certificate and to be recognized as the legal parents. The gestating woman was not considered to be the mother of the child and the couple did not have to adopt the child.[18]

In the case of surrogate motherhood, where the woman provides the gamete and gestates the fetus, the suggestion has again been made that the adoption model should apply. However, the adoption model may not be an appropriate one for surrogacy to follow. Most court cases dealing with surrogacy have explicitly rejected the adoption model.[19] The reasons for the existence of certain protections in the adoption context are not present in the surrogacy context. For example, a surrogate makes the decision to give up the child in advance of conception at a time in which she can make an informed, unemotional reflection about whether she wants to bear a child for another couple. This is unlike the biological mother in a traditional adoption who may unintentionally become pregnant and encounter emotional dilemmas and stigmatization during the pregnancy and may not be able to make an adequate assessment at that time about whether or not she wishes to give the child up.

Whenever there is a legal situation in which parental rights are transfered, the law requires that at a certain point in time that decision is final. For example, some states have laws in the context of traditional adoption that provide that the adoption is final six months after birth. It is easy to imagine a situation in which a mother seven months after the birth or seven years afterward may want the child back. Such a mother may present as compelling a picture as Mary Beth Whitehead did in her love and desire for her child. Nevertheless, we do not reopen adoptions once the time has passed, unless there is proof of coercion or fraud.

I believe that with respect to surrogacy, the point in time at which the decision is final should be before the birth, rather than after the birth. This difference in policy is appropriate due to the difference in circumstances. The reason we give an already-pregnant woman a chance to change her mind after the child is born is because we want to assure that the woman has a chance to make an informed, unpressured decision. In contrast, a surrogate can make her decision to give up the child in advance of conception at a time in which she can make an informed reflection about whether she wants to bear a child for another couple. She can take as long as she wants to decide whether or not she should be a surrogate. She is not faced with the fait accompli of an existing pregnancy about which she must make a difficult choice. Instead, the potential surrogate has a range of choices and alternatives to pregnancy for how she will spend her time.

Moreover, the biological mother in the traditional adoption situation has gotten pregnant as part of a personal relationship of her own. In many, many instances, she would like to keep the child but cannot because the relationship is not supportive or she cannot afford to raise the child. In contrast, the conceptus being carried by a surrogate mother or surrogate carrier would not even exist were it not for the couple's decision to create a child as part of their relationship.

In one study of women who had gotten pregnant within a relationship and given their children up for adption, all of the women "perceived relinquishment [of the child] as an externally enforced decision that overwhelmed their internal wish for continued attachment to the baby."[20] In contrast, in surrogate motherhood, the surrogate makes her own voluntary decisions to begin the pregnancy and give up the child.

In addition, the potential effect on the child is much different when there is a change of mind by a surrogate who has promised the child to its biological father in contrast to a change of mind by a biological mother who has promised the child to strangers in the adoption situation. The strangers in the adoption situation have no legal link to the child, so the child immediately becomes part of the biological mother's family, with no period of insecurity. In contrast, in surrogacy, the man wishing to rear the child is the child's biological father. As the Kentucky Supreme Court has pointed out, the man already has a legal relationship to the child. The surrogate's mind change thrusts the infant into legal uncertainty, requiring a lengthy court battle to determine who will be given the opportunity to rear the child.

In order to avoid that possibility, it is important to uphold the pre-conception intent of the parties in determining who the legal parents are. In most instances — 99% of the time — this will be exactly what all the parties want and it will be helpful to have legal sanction to that effect. There may be some surrogates, however, who do change their minds and are emotionally harmed by this approach. In my opinion, however, it is more appropriate to put the risk of harm on the few women who change their minds after signing a contract rather than have the risk borne by all the surrogate children who would be in legal limbo if surrogacy custody arrangements were not clearly enforceable. In fact, if there is any good that has come of the Baby M case it is that it has discouraged women who are unsure of their feelings from volunteering to be surrogates.

Letting the pre-conception intent of the parties govern who the legal parents are will have a beneficial effect on the child, since he or she will know who his or her legal parents are and will not be subject to a lengthy custody battle (with uncertainties creating potential damage to the bonding process). In addition, it may discourage women who are not entirely sure that they want to be surrogates from participating in the procedure. Under current law, with the surrogate being recognized as the legal mother, a woman who is uncertain about whether she can give the child up may nonetheless agree to be a surrogate because of the possibility that she will have a second chance at the child after its birth before the adoption procedure.

An important lesson learned during the course of the Baby M case was the overwhelming need to avoid such litigation in the future. Numerous editorials pointed out that all the participants in the litigation -- the Sterns, the Whiteheads, and most importantly, the child herself — were harmed by the anxieties and publicity of a trial to determine who her legal parents were. It is important to have clear legislation determining parenthood in advance. A proposed New York bill does this by providing for the enforcement of the contract, so the child can, immediately upon birth, be in the care and custody of her intended parents.

In the wake of the Baby M case, there has been much criticism of couples who use alternative reproduction, such as in vitro fertilization, donor insemination, or surrogacy. They are viewed as being selfish because they want a biological child. Yet that is a very human desire, one that is morally appropriate, and one that our constitutional principles protect. The lashing out against couples who turn to surrogacy reminds me of a statement by columnist Erma Bombeck. She was childless for the first six years of her marriage and suffered two miscarriages. She said "an infertile person gets about as much sympathy as an 83 pound woman who is trying to gain weight."

I'd like to applaud the Select Committee for holding these hearings and attempting to establish policy which reflects compassion for infertile couples, while at the same time providing sufficient protections for the third party participants (such as egg donors, sperm donors, embryo donors, or surrogates), the potential children, and the legitimate interests of society.

FOOTNOTES

1. United Nations, Demographic Yearbook (1984). For information on racial differences in infant mortality in the United States, see Binkin, Williams, Hogue, and Chen, "Reducing Black Neonatal Mortality: Will Improvement in Birth Weight Be Enough?" 253 Journal of the American Medical Association 372 (1985).

2. Allen, "Effects of Nutritional Status on Pregnancy and Lactation," 101 in Malnutrition: Determinants and Consequences (1984).

3. See, e.g., L. Andrews, Deregulating Doctoring: Do Medical Licensing Laws Meet Today's Health Needs? 3 (1983).

4. Prime among these have been statutes regarding research and services in connection with the prevention of birth defects. See L. Andrews, State Laws and Regulations Governing Newborn Screening (1985).

5. For information about such hazards, see L. Andrews, New Conceptions: A Consumer's Guide to the Newest Infertility Treatments Including In Vitro Fertilization, Artificial Insemination, and Surrogate Motherhood 20-22 (1985).

6. See, e.g., presentation of Dr. Burton Sokolove at the Child Welfare League of America Annual Meeting, March 18, 1987.

7. Some studies have found that there is a slight overrepresentation of adopted children using mental health services, but this may be due to the fact that adoptive parents are more sensitive to the psychological needs of their children and adoptive parents are generally more affluent (and more affluent people make greater use of mental health services).

8. "Surrogate Mothers: A Newsweek Poll," Newsweek 48 (January 19, 1987).

9. See, e.g., The Gallup Poll: Public Opinion 1978, Survey #108-G at p. 270, American Institute of Public Opinion (60% of people approve of IVF, 27% disapprove); Andrews, "Yours, Mine, and Theirs," 18 Psych. Today 10, 28 (December 1984) (reporting on survey by psychologist Annette Brodsky showing public approval of IVF and AID).

10. See, e.g., Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth," 69 Va. L. Rev. 405 (1983); Andrews, "Legal Status of the Embryo," 32 Loy. L. Rev. 357, 358-361 (1986).

11. Andrews, "Informed Consent and the Decisionmaking process," 5 Journal of Legal Medicine 163 (1984).

12. Applebaum and Roth, "Treatment Refusal in Medical Hospitals," in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship Vol. II 67 (1982).

13. Only 53 of 123 clinics responded.

14. Marrs, "The American Experience," Fourth World Congress on In Vitro Fertilization, Melbourne, Australia, November 19, 1985.

15. Daniel Callahan raised questions in print about the seeming paradox of choosing women to be surrogates on the basis of their willingness to give up the child. Callahan, "Surrogate Motherhood: A Bad Idea," *The New York Times*, January 20, 1987. It's almost as if he fears that such women are unloving and will pass on unloving genes to their children. After meeting numerous surrogates, I can assuage Dr. Callahan's fears. I find surrogates to be very loving and very special. A woman has to be altruistic and sensitive to the needs of the infertile in order to be a surrogate. Otherwise, she would not undergo the risky process of pregnancy for mere $1.50 an hour. The pregnant surrogate lovingly talks to and sings to the baby inside her just as any pregnant woman does. She bonds to that baby, but she does so in a different way. I have heard a surrogate say to her pregnant belly, "This is what your parents are doing today," referring to the intended parents.

    I don't think surrogacy discourages pregnant women from being nurturing. Moreover, it provides a great opportunity for men to be nurturing — men like Mr. Stern whose daughter's eyes light up when he walks into the room. Men who otherwise would not be able to rear a child because they are disqualified from adoption by their age or religion, or by a shortage of infants.

16. VanDe Velde, "The Future of Surrogacy," *Chicago Tribune* (January 25, 1987).

17. These states are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming.

18. *Smith v. Jones*, No. 85 532014 02 (Michigan Cir. Court, Wayne County, March 14, 1986).

19. *See, e.g.*, *In the Matter of Baby "M"*, No. FM-25314-86E (Bergen County, N.J. Supreme Court, March 31, 1987); *In re Adoption of Baby Girl, L.J.*, 505 N.Y.S.2d 813 (1986).

20. Rynearson, "Relinquishment and Its Maternal Complications: A Preliminary Study," 139 *Am. J. Psychiatry* 338 (1982).

STATEMENT OF ROBERT MARSHALL, DIRECTOR OF RESEARCH, THE CASTELLO INSTITUTE OF STAFFORD, VA

Mr. **Marshall.** Thank you very much for the opportunity to testify here today.

Mr. Chairman and members of the committee, to everything there is an origin and a history. Biologically, each person somehow results from the fusion of two seeds, a male and female gamete, via the process of sexual intercourse.

The normative social context of this union, even in the pre-Christian era, was held to be marriage, whether formal or informal, usually monagamous but occasionally bigamous.

Deviations from these norms were heretofore possible only through the social context of human generations, i.e., a nonmarital pregnancy. Technological innovations now make presently possible the separation of sexual intercourse from the biological process of fertilization, at least for the early stages of human development.

Sexual intercourse without babies has been followed by babies without sexual intercourse. This simply completes a circle begun with the introduction of birth control, which was the entering wedge facilitating this divorce, making it socially acceptable if not totally without controversy.

Hence, the present day phenomenon of alternative reproductive technologies competing with conventional sexual intercourse in the generation of new humans with the marriage of the seed donors—parents may be inapt here—as an accessory.

Medical, ethical, biological, social and personal consequences for thought, behavior and values that have been derived from the widespread introduction of birth control, while certainly part of the present set of social norms, was not always so.

Only in 1931 did the consensus in the culturally Christian Western world concerning the illicitiness of birth control break down. Previously, Martin Luther, John Calvin, John Knox and other reformers all agreed with the Popes that human reproduction could not be separated from human sexuality without grave objective moral fault and with terrible social consequences, some of which could only then dimly, if at all, be seen.

How else explain—than the widespread availability of birth control now for minors without parental knowledge or consent courtesy of the U.S. Congress—that today's teenagers and young people view premarital sex as less wrong than their counterparts previously? Also, the evaluation of extramarital sex has slipped in its evaluation of wrongness on college surveys.

And your Congressional predecessors also reflected this earlier consensus when in 1873 an overwhelmingly Protestant United States Congress passed the Comstock Act which outlawed drugs or devices that caused, that prevented conception or caused abortion and they also outlawed pornography in interstate commerce. They saw a social connection between them and the consequent sexual immorality and family breakdown.

The U.S. Congress subsequently re-enacted the Comstock law on at least ten different occasions with the final vestiges of that statute prohibiting the unsolicited mailing of contraceptive advertisements to minors, then struck down in *Young* v. *Bolgers* in 1985.

That social understanding has been lost with the passage of time and the advent of technological innovations affecting conception and abortion.

But secular commentators were not all so obtuse. In 1979, journalist Walter Lippman opined that the Christian churches were correct in assessing birth control as the most revolutionary practice in the history of sexual morals. Another contemporary, former Catholic Will Durant, agreed, suggesting that contraceptives were quote "the proximate cause of our changing morals." And unlike the song from the prior generation which noted that "love and marriage go together like a horse and carriage," the current separation of sex from reproduction has become so widespread that Washington Post columnist Judy Mann could write in 1981 that ". . . half of today's sexually active teens still don't know that sexual intercourse is a leading cause of pregnancy." What the other leading causes of pregnancy were was not mentioned by Ms. Mann.

I read the article six times and that's what it said.

And whereas when I was in high school during 1960 to 1962, giving a minor a birth control drug or device was a misdemeanor, now Federal money is made available for the same purpose, some even demanding that birth control clinics be set up within the confines of the public school.

Is this school birth control movement simply the entering wedge by which today's female adolescents get used to telling a representative of the government that they took their birth control pill today with the inevitable consequence being State planning of births, which we virtually have in Red China? There is, however, nothing new in such totalitarian visions.

Plato, in his book, "The Republic" described the role played by birth control in establishing a utopian but totalitarian state. Its timelessness is incredible.

We had Socrates state, "I mean, I replied, that our rulers will find a considerable dose of falsehood and deceit necessary for the good of their subjects: we were saying that the use of all these things regarded as medicines might be of advantage."

Glaucon responds: "And we were very right."

Socrates retorts: "And this lawful use of them seems likely to be often needed in the regulations of marriages. . . . Now these goings on must be a secret which the rulers only know."

The discussion immediately following deals with the application of animal husbandry techniques to the human social order starting with the need to expose handicapped babies, abort children from incestuous unions, abolish monogamous marriage and familiar child bearing, separating natural mothers from their children and even prohibiting them from breast feeding.

Attempting to apply this egalitarian, equalitarian, eugenic goal has been the decades long effort, if not the pre-eminent goal, of the Planned Parenthood program starting with founder Margaret Sanger's birth control program which sought the elimination of live births of those she deemed inferior. Advertisements for her Planned Parenthood League sponsored birth control conferences in 1921 and 1922, promised that birth control would be an effective remedy for feeblemindedness, mental defectives, paupers and others of the unfit.

Early in President FDR's New Deal, Sanger proposed in 1934 a baby code fashioned after FDR's National Recovery Act. She claimed one, the baby code was needed to reduce the production of babies by the unfit so as to reduce public charity and relief. Two, it would function through tax supported birth control centers. Three, would mandate that a marriage license gave permission for a common household, but not babies. Four, would issue birth permits only to prospective parents who were deemed healthy.

The first two of her goals are common place in this country and the latter two are practiced in Red China. For example, in a recent issue of Science Magazine, Population Council writers seriously suggested that the one child policy be liberalized to a two child policy. There was no question that the government had the right to control the fertility of its citizens, and in this country, we have had the experience and theories of the Supreme Court decision Buckley v. Bell, in which Justice Holmes said three generations of idiots are enough.

According to writer Allan Charles, until World War II, only a few of the more sophisticated racists such as Planned Parenthood members Lothrop Stoddard and Edward East and Guy Irving Burch saw the birth control movement as an answer to their elitist dreams.

The association of Planned Parenthood with the Eugenics movement involved more than the publication of a few articles to gain respectability. They also shared many board members.

In 1938, Planned Parenthood, then named the Birth Control Federation of America, adopted explicit eugenic goals as part of their, quote, Ultimate Objectives: A. To democratize and make universally available the best scientific knowledge of contraception. B. To encourage the increase of the birth rate where health, intelligence and favorable circumstances tend to promote desirable population growth. C. To discourage the increase of that part of the population perpetuating inheritable or transmitable diseases.

Although the names were changed, the alliance would continue, partially bearing fruit with the passage in 1976 of the National Genetic Diseases Act which has greatly facilitated the availability of people planners to diagnose presently incurable genetic or structural defects in children in the womb and then offer abortion as a method of treatment.

Although alpha feto protein testing and chorionic villus sampling is seeing increasing utilization, the major means for detecting prenatal defect is still amniocentesis which has legitimate use in the cases of RH fetal/maternal blood incompatibility. However, if done early in pregnancy, it usually amounts to a search and destroy mission.

As a logical outgrowth of this, California presently mandates that physicians must offer neural tube defect detection via alpha feto protein screening. And, while women may refuse the test, the burden is on the woman to refuse the medical authority figure, a doctor operating under state law.

Moreover, while the AFP screening has been implemented as a cost saving measure, the certitude of the screening testing procedure has been shown to be subject to errors where laboratories which do less than 500 specimens per week had difficulties. For example, laboratory reports to clinicians may lead to misdirecting 43% more pregnant women with positive drift into further and possibly invasive diagnostic procedures.

The consequence of birth control on medicine and medical ethics affecting women and children has been enormous.

At a 1965 population control conference, Dr. Alan Guttmacher stated that before 1960 medical opposition to birth control including the following reasons. One, preserve life. Two, do no harm. Three, won't play God syndrome. Four, Catholic Hospital staff privileges.

Dr. Guttmacher states that somehow preventing the creation of a new life, was perceived as somehow antithetical to a doctor's primary purpose. The ancient Hippocratic medical philosophy directed a physician to refrain from action rather than doing something where the action harms the patient and the won't play God attitude which included—prevented birth control, was also frequently voiced, quote, in the areas of sterilization, therapeutic abortion, donor artificial insemination and withholding resuscitative techniques to seriously malformed infants in the delivery room.

Former PPFA Medical Director, Dr. Mary Calderone has lamented that babies could not be classified as dangerous epidemics and that birth control proponents did not promote birth control in the same manner as the polio vaccine.

Replacement of the Hippocratic Oath by this philosophy, what's right for me, in the realm of medicine in the last 40 years is so complete that an attempt in Congress to have Federally funded State and local health planners merely evaluate their health goals and plans by the Hippocratic Oath is with the health systems agencies on an amendment offered by former Congressman Ron Paul, lost on a vote of 364 to 55 with 15 not voting in July, 1979.

Another inevitable spillover effect of women taking medicine, the Pill, to prevent babies, is the legitimization of taking drugs for other than medical purpose, i.e., curing of a disease or alleviating pain. Thus, doctors lure the healthy to themselves and not just the sick.

Certainly by the Pill is the most unique drug ever given to women. Conventionally understood in normal medical therapeutics, drugs are chemical substances, quote, "used to counteract the effect of disease or to reinforce the tissues in their struggle to maintain their functions", end quote. What disease is prevented by the pill?

Indeed, if pleasure is the primary motivational factor accounting for the current social use of the pill, how is this different from other non-medical, but recreational drug use? Moreover, the effects of the artificial chemical steroids in the Pill are ubiquitous, just think about it, and affect a woman's entire physiology as is evidenced by the Pill's ability to affect the parameters of normalcy on over 100 medical tests.

Last, its mode of action is not simply contraceptive. Its primary mode of action is as a sterilant, second, as an abortion, and third, it's contraceptive.

The euphemisms used by official medicine to distort public understanding of the abortion-causing actions of the Bill and the systematic attempts within the medical profession to alter medical terminology in textbooks and dictionaries will only serve in the long run to cause distrust and further prepare the ground for other non-medical, anti-social and eventually totalitarian uses of medicine.

In the case of *Diamond* v. *Charles,* 1984 term, a question at bar was whether the State of Illinois could require physicians who prescribe or administer abortifacients to inform their patients that they had done so. The court dismissed the case on other grounds, but let the Illinois law be struck down. Thus, doctors have a unilateral right to prescribe an abortifacient without informing the woman.

This finesse about the origin of life, of beginning of pregnancy, is carried on in medical journals without a second thought. For example, when a pregnant state is desired, the journals read as follows. "Highly sensitive early pregnancy tests that are positive about the time of implantation, seven days after conception, are being used to estimate the extent of pregnancy losses that occur between implantation and the time after the first missed menses when standard pregnancy tests can be employed."

When a non-pregnant state is desired, without raising the red flag of abortion, the following appeared in the same journal a week later. "These preliminary studies suggest that RU-486 holds promise as a safe and effective form of fertility control that can be administered once a month." The researcher designated it as a contraceptive.

We have to phrase "every child a wanted child." In either case, it is sexual intercourse which is freed, allegedly, except in the cases of contraceptive failure, from the consequences of the baby.

Notice that when Planned Parenthood and others use the phrase "wanted baby," such babies have rights. Unwanted babies don't and they are morally equivalent to disposable property. But still under the wanted baby scheme, where do rights come from? From being wanted, of course, but who is it that does the wanting or the conferring of rights?

Interestingly, with conventional intercourse, it is not the father nor is it a prospective adoptive couple. No, it is the pregnant woman alone who gets to confer rights. Converse the situation and the contractual relationship of in vitro where the father got to control the rights of wantedness.

This explains why Planned Parenthood would never use the phrase, "every child a valuable child." Why? Because the statement would recognize the intrinsic worth of the child irrespective of whether the father and mother, etc., wanted the baby. The next logical question would be who put the value there and why is the child valuable? That was answered in Genesis 1:26 "let us make man in our image after our likeness."

This view, however, was challenged by Dr. Guttmacher who stated in a 1968 abortion symposium, "My feeling's that the fetus, particularly in its early intrauterine life, is simply a group of specialized cells that do not differ materially from other cells. I do not think they are made in God's image. I think they are made in man's image. I just feel that under certain conditions, the elimination of life of this type is justified."

In 1955, Planned Parenthood President, Dr. William Vogt stated he believed human nature was changeable and should be changed. He stated, quote, "Indeed I believe we must change human nature at a rate far more rapid than we have in the past."

English writer, C.S. Lewis stated in the Abolition of Man, quote, "In reality, if one age really attains, by eugenics and scientific education, the power to make its descendants what it pleases, all men who live after it are the patients of that power." Lewis also noted in a comment that applies to the technology of birth control, that all of the control over nature, quote, "generally turns out to be a power exercised by some men over other men with nature as its instrument."

This is moral consequentialism which was elaborated in its, I guess, most logical forms by Dr. Joseph Fletcher at a 1981 Planned Parenthood conference. He went on to state, quote, "Without elaboration, sex is morally acceptable in any form, hetero, homo, auto, bi or poly." And looked at from the ethical perspective or from the point of view of a moral philosopher, I want to add that what makes any sexual act right or wrong is its consequences, because in and of itself, sex is neither good nor bad, neither praiseworthy nor blameworthy and its ethical significance depends upon the values it seeks to realize.

Now, Fletcher deviated from the norm which was called good in nature. Many Christians have done this as well.

Protestant theologian, Dietrich Bonhoeffer, has offered an insightful analysis in 1940 about the abandonment of the natural order by Protestant theology.

"The significance of the natural for the gospel was obscured and the Protestant Church was no longer able to return to the clear word of direction in the burning questions of natural life. She thus left countless human beings unanswered and unassisted. The consequences of this decision were grave and far reaching. If there were no longer any relative distinctions to be made within the fallen creation, then the way was opened for every kind of arbitrariness and disorder and natural life with its concrete decisions and disorders, was no longer subject to the responsibilities to God. The sole antithesis to the natural was the word of God. The natural was no longer contrasted with the unnatural."

This has also been adopted in some—Catholic theologian Father Charles Curran.

Frankly, turning to the moral norms that inhere in nature, that many critics of the recent Vatican instruction condemning artificial technology reproduction completely miss.

For example, Mr. Charles Krauthammer's own Syllabus of Errors, The Ethics of Human Manufacture, suggests that nuance will avoid the Frankensteinian consequences of modern reproductive technology and the sexual straightjacket Vatican celibates are preparing for us.

He states that allowing experimentation on a pre-14 day old embryo, in vitro human, allows clinicians to implant only the quote, "best," in vitro humans into women and without the 14 day line, tossing the spares would be murder. Moreover, balancing the social good of achieving fertility for a couple offsets the rights of say a 16-cell organism. My medical embryology book, Langman, 1969, notes that at 4½ days after fertilization, researchers counted 107 cells, but of course this sly injection of size as a criteria of who has rights obscures the real points, namely that the lines drawn by the Deity as recognized by the Vatican challenge Mr. Krauthammer's right to draw his own bright lines of moral demarcation.

He decries involuntary sterility and the real pain childless couples experience, but then fails to note the great number of couples who are now involuntarily sterile because they resorted to allegedly reversible birth control or induced abortion, both condemned by compassionless Catholic teaching.

Lastly, he states that "artificial sex [he means birth control] is a challenge to personal relationships." Oh, yes, with more than 50 venereal diseases including AIDS, up from 5 in 1955, a 50% divorce rate, one of three pregnancies aborted, and out-of-wedlock pregnancy rates higher than any time in U.S. history, I have to agree.

But to believe the birth control debate is settled, ignores the sage observation of New Republic co-founder, Walter Lippmann, who stated whether it was hygienic—birth control was hygienic, eugenic or economic, it is the most revolutionary practice in the history of sexual morals.

Even a Catholic critic of the instruction misses the points.

Mr. MORRISON. Excuse me.

Mr. MARSHALL. Yes.

Mr. MORRISON. Could you sum up? You've been going for more than fifteen minutes.

Mr. MARSHALL. I'm sorry. Okay. It's just that I'd like the chance to ask some questions of the witnesses.

Mr. MORRISON. All right.

Mr. MARSHALL. We just have some questions which are in here which we think flow from this practice, one of which is some of these companies are, in fact, achieving conception in IV techniques and they don't—they may not know that the conception and they won't know—is the result of the natural intercourse rather than the alleged in vitro technique and there's probably no way to understand it.

We make one suggestion that surrogate motherhood be abolished and can be done so under the 13th Amendment, considering the child selling here as a badge and incidence of slavery, which the Supreme Court recognized could be done in, I think, the 1870s. So I'll just stop right there.

Mr. MORRISON. Thank you.

[Prepared statement of Robert G. Marshall follows:]

Prepared Statement of Robert G. Marshall, Director of Research, The Castello Institute of Stafford, VA

Mr. Chairman and members of the Committee, for everything there is an origin and a history. Biologically, each person somehow results from the fusion of two seeds -- a male and a female gamete -- via the process of sexual intercourse. The normative social context of this union, even in the pre-Christian era, was held to be marriage whether formal or informal, usually monogamous, but occasionally bigamous.

While deviations from these norms were heretofore possible only for the social context of human generation, i.e. a non-marital pregnancy, technological innovations now make presently possible the separation of sexual intercourse from the biological process of fertilization at least for the early stages of human development.

Sexual intercourse without babies has been followed by babies without sexual intercourse. This simply completes a circle begun with the introduction of birth control, which was the entering wedge facilitating this divorce -- making it socially acceptable, if not totally without controversy. Hence, the present day phenomena of "alternative reproductive technologies" competing with conventional sexual intercourse in the generation of new humans with the marriage of the "seed donors" -- parents may be inapt here -- as an accessory.

While today's hearing is held in the context of the Baby "M" Surrogate Mother case from New Jersey, and the Vatican's Instruction on questions regarding the origin and dignity of human procreation, there is a larger background from which these present events can be said to have emerged.

The medical/ethical, biological, social, and personal consequences for thought, behavior and values that have been derived from the widespread introduction of birth control, while certainly part of the present set of social "norms", was not always so. It has only been within this century, and frankly spawned within this country, that the consensus in the culturally Christian western world concerning the licitness of birth control was broken. Martin Luther, John Calvin, John Knox and other of the "Reformers" all agreed with the Popes, that human reproduction could not be separated from human sexuality without grave, objective moral fault, and with terrible social consequences some of which could only then dimly, if at all, be envisioned.

How else explain -- than the widespread availability of birth control now for minors without parental knowledge of consent courtesy of the U.S. Congress -- that today's teenagers and young people view pre-marital sex as "less wrong" than their counterparts in 1929 through 1949? Indeed, the change in the perceived relative wrongness of premarital sex by college students in a 1983 survey led the shifts in changes of moral judgements from students earlier. "The only behavior for which current acceptance is far above previous levels of approval is having sexual relations while unmarried. ... Half of the sample of current undergraduates rated premarital sex as "0" on the wrongness scale." Zero was the score for items held least wrong or not wrong, with "10" being most wrong. Moreover, while in previous years having an extramarital affair was perceived to be the most wrong of all behaviors contrasted, by 1983 the relative ranking drops, although the mean wrongness is rather constant. [Aidala, Angela A. and Greenblat, Cathy S. "Changes in Moral Judgements Among Student Populations: 1929-1983", Youth and Society, Vol 17, No. 3, pp 221-235, March, 1986]

And your Congressional predecessors also reflected this earlier consensus, when, in 1873, an overwhelmingly Protestant United States Congress passed the "Comstock Act" which outlawed contraception, abortion, causing drug or device, pornography and saw a social connection between them and consequent sexual immorality and family breakdown. The U. S. Congress subsequently reenacted the "Comstock law" on at least 10 different occasions with the final vestiges of that statute -- prohibiting the unsolicited mailing of contraceptive advertisements to minors -- being struck down in Young vs. Bolgers [1985].

That social understanding has been lost with the passage of time and the advent of technological innovations affecting conception and abortion. And while it may tingle ears of some who listen, the present social landscape tells us that the assumptions of that 1873 statute had touched on a truth about human nature. And this is so, even if many today might find it embarrassing, if not outrageous or pathetically laughable.

But, secular commentators were not always so obtuse. In 1929 journalist Walter Lippman opined (where) that the Christian Churches were correct in assessing birth control as the "most revolutionary practice in the history of sexual morals". Another contemporary philosopher and then former Catholic, Will Durant, agreed, (where) suggesting that contraceptives were the "proximate cause..of our changing morals."

Unlike the song from the prior generation which noted that "love and marriage go together like a horse and carriage", the current separation of sex from reproduction has become so widespread that Washington Post columnist Judy Mann could write in 1981 (pg. date) that:

"... half of today's sexually active teens still don't know that sexual intercourse is a leading cause of pregnancy.". What the other leading causes of pregnancy are was not mentioned by Ms. Mann.

Earlier in this century Freud, taking issue with the above, would write in his "General Introduction to Psycho-Analysis:" "Moreover, it is a characteristic of all the perversions that in them reproduction as an aim is put aside. This is actually the criterion by which we judge whether a sexual activity is perverse -- if it departs from reproduction in its aims and pursues the attainment of gratification independently."

Quotes no line

And, whereas when I was in high school [1960-62], giving a minor a birth control drug or device was a misdemeanor, now, federal money is made available for the same purpose. And some even demand that birth control clinics be set up within the actual confines of public schools. Is this school birth control movement simply the entering wedge by which today's female adolescents get used to telling a representative of the government that they took their Birth Control Pill today with the inevitable consequence being state planning of births as we virtually have in Red China?

But there is nothing new in such totalitarian visions. Approximately three hundred and fifty years before the birth of Christ, the Greek philosopher, Plato, described in his book "The Republic," the role which would be played by birth control in establishing ~~the~~ a utopian but totalitarian state. It's timeliness for the present discussion is remarkable.

In book V, at [459], Plato records the following dialogue:

Socrates:"I mean, I replied, that our rulers will find a considerable dose of falsehood and deceit necessary for the good of their subjects: we were saying that the use of all these things regarded as medicines might be of advantage.

Glaucon."And we were very right."

Socrates:"And this lawful use of them seems likely to be often needed in the regulations of marriages. ... Now these goings on must be a secret which the rulers only know."

The discussion immediately following deals with the application of animal husbandry techniques to the human social order starting with the need to expose handicapped babies, abort children from incestuous unions, abolish monogamous marriage and familial child rearing, separate natural mothers from their children and even prohibiting them from breast feeding.

Elsewhere in Book V, Plato specifies that if the sexes differ only in that men beget and women bear children that "this does not amount to a proof that a woman differs from a man in respect of the sort of education she should receive." Plato also suggests that as men and women "...differ only in their comparative strength..." that the wives of the guardians should "...share in the toils of war and the defense of their country".

It takes only a passing familiarity with the times to see similar events in American culture such as Plato described as existing only in his mythical state.

Attempting to apply this equalitarian, eugenic goal has been the decades long effort -- if not preeminent goal -- of the Planned Parenthood program starting with founder Margaret Sanger's birth control program which sought the elimination of live births of those deemed inferior. Advertisements for her ABCL [Planned Parenthood League] sponsored birth control conferences in 1921 and 1923 promised that birth control would be an effective remedy for feeble-mindedness, mental defect, defectives, paupers and other unfit.

That all these evils were hereditary and curable by birth control was an implicit assumption. It was no accident that Sanger's efforts coincided with those of eugenic organizations.

Early in President Franklin Delano Roosevelt's New Deal, Planned Parenthood's Margaret Sanger, in 1934 proposed a "Baby Code" (when) fashioned after ~~the~~ FDR's ~~FRD's~~ National Recovery Act. Sanger claimed her Baby Code: 1. was needed to reduce the production of babies by the unfit so as to reduce public charity and relief; 2. would function through tax supported birth control centers; 3. would mandate that a marriage licence gave permission for a common household, but not babies; 4. would issue birth permits only to prospective parents who were deemed "healthy".

The first two of her goals are common place in this country, and the latter two are practiced by Red China right now. In a recent issue of Science magazine, (date) Population Council writers seriously suggested that the one child policy be liberalized to a two child one. There was no question that the government had the right to control the fertility of its citizens. Are we next?

According to writer Allan Chase, (in ?) until World War II, only a few more sophisticated racists, such as Lothrop Stoddard, Edward M. East, and Guy Irving Burch,"saw the birth control movement as an answer to their elitist dreams..."

Lothrop Stoddard and Edward M. East were both on the National Council of the American Birth Control League (ABCL) while Sanger was head, and both wrote for Sanger's Birth Control Review. Guy Irving Burch also contributed articles. One of Sanger's lovers, Havelock Ellis, wrote a book review (where?) about Lothrop Stoddard's The Rising Tide of Color Against White Supremacy and noted that Stoddard "is content to concern himself mainly with measures which may contribute to the maintenance of white supremacy."

The association of Sanger and her American Birth Control League OVE [Planned Parenthood's earlier name] with the Eugenics movement involved much more than the publication of a few articles to gain respectability. The ABCL and the American Eugenics Society also shared many board members.

In 1938 Planned Parenthood, [then named The Birth Control Federation of America], adopted explicit eugenic goals as part of their "Ultimate Objectives": A. "To democratize and to make universally available the best scientific knowledge of contraception..."; B. "To encourage the increase of the birth rate where health, intelligence and favorable circumstance tend to promote desirable population growth." C. "To discourage the increase of that part of the population perpetuating inheritable or transmissible diseases"

Although the names would change with the American Eugenics Society eventually becoming the Society for the Study of Social Biology, board members from or prominent members of Planned Parenthood would appear in eugenic publications through the 1960's.

So, Planned Parenthood's eugenics efforts have born much of what

Sanger sought but could only anticipate because of unfavorable social attitudes or a lack of birth selection technology.

The passage in 1976 of the National Genetic Disease Act, Public law 94-278, has greatly facilitated the ability of the people planners to diagnose presently incurable genetic or structural defects of children in the womb, and then offer abortion as a method of treatment. Whereas the old eugenic movement was overtly racist, ideological and elitist, the new eugenics movement manages to subtly combine these qualities under a newer scientific rigor aided by statistics and prenatal diagnosis.

Although alpha feto protein testing and chorionic villis sampling are seeing increasing utilization, the major means of testing for prenatal defects is still amniocentesis which has a legitimate use in cases of RH fetal/maternal blood incompatibility. However, if done early in pregnancy, it usually amounts to a fetal search and destroy mission because the diseases or physical impairments selected for identification have no known cure.

As a logical outgrowth of this, California presently mandates (cite) that physicians must offer neural tube defect detection via alpha feto-protein screening. While women may refuse the test, the burden is on the woman to refuse the medical authority figure, a doctor operating under state law, in this case.

Moreover, while the AFP screening has been implemented as a cost-saving measure, the certitude of the AFP screening testing procedure has been shown to be subject to errors where laboratories do less than 500 specimen tests per week. For example, "laboratory reports to clinicians may lead to misdirecting 43% more pregnant women (with positive drift) into further (possibly invasive) diagnostic procedures." [Macri, James N., Dr. et. al. Maternal Serum alpha fetoprotein Screening", Am. J. Obstet. Gynec., March 1987 Vol. 156, No. 3]

The consequences of birth control on medicine and medical ethics affecting women and children have been enormous.

At a 1965 population control conference Planned Parenthood President, Dr. Alan Guttmacher, stated that before 1960 medical opposition to birth control included the following reasons: 1. Preserve life; 2. Do No Harm; 3. Won't Play God Syndrome; 4. Catholic Hospital Staff privileges.

In elaborating on the above, Dr. Guttmacher notes (when?) the specific linkage of birth control to our present topic, namely, that: Preventing the creation of a new life was perceived as somehow antithetical to a doctor's primary purpose; The ancient Hippocratic medical philosophy directed a physician to refrain from action rather than "doing something when the action harms the patient"; And, the Won't Play God Attitude, which included preventive birth control was also frequently voiced "...in the areas of sterilization, therapeutic abortion, donor artificial insemination and withholding resuscitative techniques to seriously malformed infants in the delivery room..."

Guttmacher's linkage of the above practices is no accident or mere personal preference, but the logical working out of Sanger's 'every child is a wanted child' philosophy. The use of drugs, devices and medical intervention to prevent pregnancy or interrupt its natural development inevitably established the notion that babies and pregnancy are some kind of disease or pathogenic condition.

Reinforcing this notion, former PPFA Medical Director, Dr. Mary Calderone, has lamented that babies could not be classified as dangerous epidemics and that birth control proponents did not promote birth control in the same manner as the polio vaccine.

In 1971, Dr. Warren Hern, a Colorado abortionist, wrote in Planned Parenthood's medical magazine (NAME, DATE) that pregnancy "is an episodic, moderately extended chronic condition...may be defined as an illness...treated by evacuation of the uterine contents..."

Attendees at the 1976 Planned Parenthood Physicians meeting were treated to a speech by U.S. Centers for Disease Control official, Dr. Willard Cates entitled, "Abortion as Treatment for Unwanted Pregnancy, the Number Two Sexually Transmitted Condition."

Replacement of the Hippocratic Oath by Planned Parenthood's 'what's right for me' ethic in the realm of medicine in the last 40 years is so complete that an attempt in Congress to have federally funded state and local health planners merely evaluate their health goals and plans by the Hippocratic Oath [Revised Geneva Version-1948] lost on a vote of 364 to 55 with 15 not voting on July 19, 1979.

Planned Parenthood's "Washington Memo" noted that the amendment offered by former Congressman Ron Paul [R-TX], who was also a doctor, "was aimed exactly at the particular goals of the health systems plans especially affecting the family planning sections". How is the 'sanctity of life' violated by 'family planning'? As the revised Hippocratic Oath maintains that "The health and life of my patient will be my first consideration .... I will maintain the utmost respect for human life from the time of its conception.", it can only be concluded that Planned Parenthood policy does not.

Another inevitable 'spill over' effect of women taking medicine [oral birth control tablets] to prevent babies is the legitimation of drug taking for other than medical purposes, i.e. curing a disease or alleviating pain. Thus, doctors lure the healthy to themselves, and not just the sick. Certainly the "Pill" is the most unique drug ever given to healthy women. Conventionally understood in normal medical therapeutics, drugs are chemical substances "used to counteract the effects of disease, or to reinforce the tissues in their struggle to maintain their functions." [D.L. Marsh, "Outline of Fundamental Pharmacology", Charles C. Thomas, Publisher, 1951.] What disease is prevented by the pill? Indeed, if pleasure is the primary motivational factor accounting for the current social use of the "Pill", how is this different from other non-medical, but "recreational" drug use? Moreover, the effects of the artificial chemical steroids in the "Pill" are ubiquitous and affect a woman's entire physiology as is evidenced by the "Pills'" ability to effect the parameters of "normalcy" on over 100 medical tests. [Amer. Jour. Ob. Gyn. Sept. 15, 1974; JAMA Sept. 23, 1974 V.229, No. 13; JAMA, Aug. 15, 1980, V. 244, No. 7.15]16]

Lastly, its mode of action is not simply contraceptive. Although the mechanisms of its antifertility effects are not thoroughly understood, it is known that the combined "Pill" operates primarily by inducing a state of temporary sterility [permanent for some women]. The second major mode of action is covert, early abortion. The 1969 FDA Pill Advisory Committee Report noted: "The second major effect is on the endometrium [womb-ed]. The progestin acts as an antiestrogen, causing alterations in the endometrial glands, and as a progestin, causing a pseudodecidual reaction. Both of these effects alter the ability of the endometrium to participate in the process of implantation." As this is the biological stage of development after fertilization, it constitutes abortion. The only "contraceptive" effect of the "Pill" is a minor one -- the "Pill" enhanced or derived cervical mucous barrier that is supposed to mitigate sperm penetration.

The euphemisms used by official medicine to distort public understanding of the abortion causing actions of the "Pill", and the systematic attempts within the medical profession to alter medical terminology in textbooks and dictionaries will serve only in the long run to cause distrust, and further prepare the ground for other non-medical, anti-social and eventually totalitarian uses of "medicine".

In the case of Diamond vs. Charles [No. 84-1379, Supreme Court October, 1984 term] a question at bar was whether the State of Illinois could require physicians who prescribe or administer abortifacients to women to inform their patients that they have done so. The Court, by dismissing the case for procedural reasons, sustained without comment the decision of the U.S. Circuit Court for Appeals for the Seventh Circuit which struck down the informed consent provision. Thus, Illinois physicians have the unilateral right to abort their pregnant patients without informing them of such actions.

The American Medical Association, the American College of Obstetricians and Gynecologists and others claimed the Illinois provision to be unconstitutional in part, because it interfered with the physician's ability to provide medically relevant information to the patient.

This "finesse" read, lie, regarding the beginning of pregnancy is carried on in medical journals without a second thought. For example, when a pregnant state is desired the medical journals read as follows: "Highly sensitive early pregnancy tests that are positive at about the time of implantation (seven days after conception) are being used to estimate the extent of pregnancy losses that occur between implantation and the time after the first missed menses when standard pregnancy tests can be employed." [Warburton, Dorothy, "Reproductive Loss: How Much is Preventable" The New England Journal of Medicine", Jan. 15, 1987 pp 158-60]

When a non-pregnant state is desired without raising the red flag of abortion, the following occurred a mere week later in the same medical journal: "These preliminary studies suggest that RU-486 holds promise as a safe and effective FORM ~~from~~ of fertility control that can be administered once a month." [Nieman, Lynnette K., et. al. "The Progesterone Antagonist RU-486: A Potential New Contraceptive Agent", The New England Journal of Medicine", Jan. 22, 1987 pp 187-90]

The chief catch phrase by which we were lured into this morass was the slogan: "Every child a wanted child", or "Children by choice, not chance". In either case sexual intercourse is freed, except in cases of "contraceptive failure", i.e. a baby, from the previously "blind" and inevitable biological consequences.

Only the children, if any, of couples practicing birth control can be called truly voluntary and planned. Married couples who 'slip up' or who do not use birth control have accidental pregnancies and unplanned families. Such persons are subject to nature, fate or forces beyond themselves and are dependent, and not autonomous.

Controlling pregnancy thus becomes an exercise of the will to power, not a surrender of love.

Notice that when Planned Parenthood uses the 'wanted' baby phrase, that such babies have rights. Unwanted babies have no rights, and are morally equivalent to disposable property. But still under the 'wanted baby' scheme, where do rights come from? From being wanted, of course. But who is it that does the "wanting" which results in the conferring of rights?

Interestingly, with conventional intercourse, it is not the father. Nor is it a prospective adoptive couple. No, it is the pregnant woman alone who gets to confer rights.

This explains why Planned Parenthood would never use the phrase, "Every child a valuable child.". Why? Because that statement would recognize the intrinsic worth of the child irrespective of whether father, mother, etc. wanted the baby. And the next logical question to ask would be 'who put the value there and why is the child valuable'? That question was answered in Genesis 1:26 "let us make man in our image, after our likeness."

Needless to say this doesn't sit well with persons who view themselves after the manner of the Deity claiming that they are their own ultimate arbiters of right and wrong. Man, in other words, is made in Man's image. Dr. Alan Guttmacher put it this way at a 1968 abortion symposium: "My feeling is that the fetus, particularly in its early intrauterine life, is simply a group of specialized cells that do not differ materially from other cells. I do not think they are made in God's image. I think they are made in man's image....I just feel that under certain conditions the elimination of life of this type is justified."

You see, the 'problem' of too many specialized 'cell collections' i.e., over population, can be "cured" by contraception, sterilization, abortion, euthanasia.

But, if the Author of Genesis is correct, how can there be too many creatures made after the likeness of absolute goodness, or God? There can be, but only in the contemplations of the demonic.

Quite obviously, Planned Parenthood ideologues are not satisfied with the current arrangement of things in the universe. In 1955, Planned Parenthood president, Dr. William Vogt, stated that he believed human nature to be changeable, and further that:"Indeed, I believe we must change human nature--and at a far more rapid rate than we have in the past."

English writer, C.S. Lewis, with remarkable foresight, pointed out in the Abolition of Man that "In reality, if one age really attains, by eugenics and scientific education, the power to make its descendants what it pleases, all men who live after it are the patients of that power." Lewis also noted in a comment that applies to the technology of birth control, that all of the control over nature "generally turns out to be a power exercised by some men over other men with nature as its instrument."

Artificial birth control is such an instrument. For on the physical level it attempts to remove the child as the natural result of sex and at the same time creating a dependency on the provider of birth control. And on the moral level birth control implies that right and wrong depend upon consequences of actions, rather than the inherent agreement with or divergence from the good established for man by God.

A logical, if not lascivious example of this type of thinking, was articulated by long time Planned Parenthood supporter, Episcopal theologian, Joseph Fletcher, at the PPFA 1981 annual meeting held in Washington, D.C.. Fletcher noted: ""I want to say carefully and without elaboration, sex is morally acceptable in any form; hetero, homo, auto, bi or poly. And looked at from the ethical perspective, or from the point of view of a moral philosopher, I want to add that what makes any sexual act right or wrong is its consequences, because in and of itself sex, is neither good or bad, neither praiseworthy nor blameworthy, and its ethical significance depends upon the values it serves and seeks to realize."

Note also how Fletcher's Planned Parenthood assumptions differ from the creation account in Genesis, where the various aspects of ? the creation were called "good" by God and not simply in virtue of their "consequences". And, in fact, the only thing called "not good" was ~~the~~ man's being alone or lack of a suitable partner [Genesis 2:17]. And perhaps, if God had not been intolerant but had listened to * Fletcher, He could have broadened His appreciation of pluralism by asking Adam and Eve what values they served and sought to realize by following the serpent's advice.

* Alas! We know what happened! God imposed His values on them and the entire natural order. For, although it is correct that all nature groans under sin, all of the created order is still under the dominion of God. Yet, the book of nature is not always viewed in a normative sense even by many Christians, and is ~~looked~~ VIEWED as in need of "editing" by secular humanists.

Writing in 1940, Protestant theologian, Dietrich Bonhoeffer, has offered an insightful analysis about the consequences of the virtual abandonment of the natural order by Protestant theology: "The significance of the natural for the gospel was obscured, and the Protestant Church was no longer able to return a clear word of direction in answer to the burning questions of natural life. She thus left countless human beings unanswered and unassisted .... The consequences of this decision were grave and far reaching. If there were no longer any relative distinctions to be made within the fallen creation, then the way was opened to every kind of arbitrariness and disorder, and natural life, with its concrete decisions and orders was no longer subject to responsibility to God. The sole antithesis to the natural was the word of God; the natural was no longer contrasted with the unnatural. For in the presence of the word of God both the natural and the unnatural were equally damned. And this meant complete disruption in the domain of natural life."

With natural law or common sense ethics abandoned, statistics replaced old norms with new ones. Dr. Herbert Ratner, a prominent birth control pill critic has written: "Biologist Alfred Kinsey of the 1948 Kinsey Report, and a pioneer of modern sex surveys, and avant guard [Catholic educated] theologian Anthony Kosnik of the 1977 report, "Human Sexuality," erred when they sought ethical norms of sexual behavior from what the majority of people did. For all they knew, they may have been measuring the sexual activities of a sick society. Germany, under National Socialism, exterminated Jews and other alleged inferior people, as well as "useless eaters", but this did not make extermination an ethical norm that corresponded to the nature of man as an individual or as a social animal."

But the abandonment of nature as a minimal behavioral norm and guide also affects Catholic theologians as well. The Rev. Charles Curran of Catholic University, a prominent dissenter from orthodox Catholic teaching on birth control would write in 1966 that "Technological and scientific progress has changed our whole outlook on reality and the world. Contemporary man does not bow before nature and conform his life to the pattern of nature." Two years later in 1968, when Fr. Curran would gain national prominence by openly leading the dissent from Pope Paul VI's encyclical, "Humane Vitae," he wrote, consistent with his pro-contraception views that: "Modern man does not find happiness in conforming to nature... Contemporary man makes nature conform to him rather than vice-versa."

This conformity of nature to man most often attempted by public health and medical practitioners, so-called, in the vast efforts to make the world safe for hedonism is purely chimerical.

A mere thirty years ago, there were five clinically apparent venereal diseases. At present there are more than fifty disease entities caused by at least 20 microorganisms or viruses that are sexually transmitted to children or sexual associates. Ectopic pregnancy, which can be life-threatening has increased in America and the western world. Sterility has increased among young women over the past 20 years. Cervical cancer is increasing among younger and younger sexually liberated women. And Acquired Immune Deficiency Syndrome, a lethal disease for which there is no cure, has spread rapidly among homosexuals in America, and has made itself present among sexually indulgent heterosexuals and children and others who are innocent victims of the sexual revolt.

These few considerations point to the conclusion that not only is it not nice to fool Mother Nature, it is not possible. Any victories are merely apparent ones.

There are three reasons for this. First, God the Father is the Author of nature: [Hebrews 3:4]. Second, the purpose which He placed in things cannot be destroyed: "Consider the work of God: who can make straight that which he hath made crooked?" [Ecclesiastes 7:13]. Third, God constituted nature to respond to man's actions in a proportional manner: "I call heaven and earth to record this day against you, that I have set before you life and death, blessing and cursing: therefore choose life that thou and thy seed may live." [Deuteronomy 30:19].

And frankly, it is the moral norms that inhere in nature that many critics of the recent Vatican instruction condemning artificial technological reproduction miss completely.

For example, take recent Pulitizer prize winner Mr. Charles Krauthammer's own Syllabus of Errors, "The Ethics of Human Manufacture" [New Republic May 4, 1987]. He suggests that "nuance" will avoid both the Frankenstein consequences of modern reproductive technology and the sexual straightjacket Vatican celibates are preparing for us.

Sorry, I must be blunt. Mr. Krauthammer not only misses the main points, he manufactures some of his own which he proceeds to manipulate for the unwary.

He states that allowing experimentation on a pre-14 day old in vitro human allows clinicians to implant only the "best" IVH's into women, and that without the 14 day line tossing the "spares" would be murder. Moreover, balancing the social good of achieving fertility for a couple offsets the rights of say a "16-cell organism". My medical embryology book [Langman, 1969] notes that at 4 1/2 days after fertilization researchers counted 107 cells. But of course, this sly injection of size as a criteria of who has rights obscures the real point, namely, that the the lines drawn by the Deity as recognized by the Vatican challenge Mr. Krauthammer's right to draw his own "bright lines" of moral demarcation.

He decries involuntary sterility and the real pain childless couples experience, but then fails to note the great number of couples who are now involuntarily sterile because they resorted to allegedly reversible birth control or induced abortion -- both condemned by "compassionless" Catholic teaching.

Lastly, he states that "Artificial sex [birth control] is a challenge to a personal relationship". Yes, with more than 50 venereal diseases including AIDS -- up from 5 in 1955, a 50% divorce rate, one of three pregnancies aborted, and out-of-wedlock pregnancy rates higher than any time in US history, well, I have to agree.

But to believe the birth control debate is settled ignores the sage observation of _New Republic_ co-founder, Walter Lippmann, who pointed out that back in the 30's the Christian churches, especially the Roman Catholic one instantly recognized that "whether or not birth control is eugenic, hygienic, and economic, it is the most revolutionary practice in the history of sexual morals."

Indeed, the Church is saying "No!" to man, because man is saying "No!" to God.

Or, let's take an allegedly Catholic critic of the Vatican

Instruction, the Washington Post's own Coleman McCarthy, whose special charism for misrepresenting things Catholic is nowhere more evident than his attempts to critique, much less make sense of what the Church says about sex.

In his column [3/14/87] Mr. McCarthy alleges that the "temporary occupant of Peter's Chair, John Paul II and his assistant, Cardinal Ratzinger, lack compassion because they have the courage to say "no" to technological manipulation and other barn yard degradations of human procreation.

Now, compassion means "suffering together with another", not acquiescing or applauding efforts to "go beyond the limits of a reasonable dominion over nature." Compassion moreover, is only possible when predicated on a desire, respect, appreciation and insistence on truth. When Christ was told by the Samaritan woman at the well that she had no husband, he replied, that as she had had five previous "husbands" and her current male companion was not her husband, she had spoken the truth and was congratulated. And although she could have stood on her personal anguish in trying to find happiness, children and fulfillment, her response was "I see you are a prophet", and not, "Where is your compassion for my exceptions?".

But, Mr. McCarthy thinks that when the Lord said "What God has joined together, let not man break asunder." that the Deity wasn't talking to journalists or infertile couples. The Vatican was so heartless as to suggest "Adoption, various forms of educational work, and assistance to other families and to poor or handicapped children." -- events which happened far more often among infertile couples when abortion was illegal and which journalists then applauded.

Curiously, both in Post reporting on this matter and Mr. McCarthy's column, no mention is made of the great number of couples who are now sterile because they resorted to allegedly reversible birth control or abortion -- both condemned by "compassionless" Catholic teaching and both of which "technologies" have increased the number of infertile, married couples. Even the "make America safe for hedonism" U.S. Centers for Disease Control has admitted this for Pill and IUD 'complications'.

Current estimates of the number of involuntarily sterile are 1 in every 5-7 couples, or 15-20%. While not all such infertility is a result of a VD, and not all VD's cause infertility, "the trends over the last twenty years show a definite correlation between the two." Effects also are felt by children as 5,000 newborns die each year from group B streptococcus infection. [Keating, Carolyn, RNC, "The Impact of Sexually Transmitted Diseases on Human Fertility.", Health Care for Women International, Vol 8, pp 33-41, 1987]

Yet, the secular response to these technological violations of the moral law are further technological deviations to achieve the "wanted" baby after so many millions of allegedly "unwanted" ones have been discarded or destroyed. And we end up with social principals like the salaried biological mother who has a duty to relinquish the child she bore pursuant to a surrogate mother contract. We also have in vitro "hatcheries" charging $3,500 and more for their petri dish experiments claiming they are more successful than nature, but who "overlook" the fact that as check-writing couples still maintain conjugal relations the baby may have resulted from natural conception! Yet the Vatican is irrational and cloaked in error.

Lastly, Mr. McCarthy claims that only "Catholic politicians" are asked to act as the "pope's lobbyists shoving legislatures around" to enact "church laws" perhaps assisted by "PopePAC" -- the Vatican's Political Action Committee -- all to the horror of "Know Nothings"?

In its reasoned conclusions the Vatican Congregation relied upon not only principles of Faith as found in Scripture which do apply to Catholic politicians even if some of them such as Governor Cuomo think otherwise. Also noted was a correct and authoritative reading of the book of nature which is applicable to all human persons and which should be defended by the public authorities of any or no Faith as necessary for the individual and the common good.

Perhaps it is otherwise in Chevy Chase, but lest Mr. McCarthy forgets, gravity applies to both Catholics and non-Catholics. It is likewise with the moral law.

As a nation we were once respected and admired for our ideals, now, after the birth control fueled sex revolt, we are merely envied for our machines. Presently, we are in the position of poet Gerard Manley Hopkins' incontinent lover who sought to derive the infinite from the creaturely, bending nature as if it were a plastic object to be molded by anyone brave enough to try. However, in the Hound of Heaven, the idolater discovers that:

"I tempted all his servitors, but to find
My own betrayal in their constancy,
In faith to Him their fickleness to me,
Their traitorous trueness, and their loyal deceit.
To all swift things for swiftness did I sue...

Fear wist not to evade as Love wist to pursue.
Still, with unhurrying chase,
And unperturbed pace,

Deliberate speed, majestic instancy,
Came on the following Feet,
And a voice above their beat--
'Naught shelters thee, who wilt not shelter Me.'"

Lastly, I realize that in a culture which operates under no or very few Christian presuppositions, indeed, finding Christian motivation behind legislative constitutionally suspect [Title XX USPHSA] that such observed may be dismissed as improper. Nevertheless, as Pagan practices make further inroads, and as technological changes increase the reach of certain social principles there will be additional questions to answer. For example:

1. Although the term "surrogate mother" is applied to the woman carrying and conceiving the child from her ovum, she is not a surrogate because she is not the "substitute" mother". In fact she becomes a temporary concubine. How is this not exploitative of women?
2. What is there to stop single women from seeking the "services " of an in-vitro "hatchery" to conceive a child according to the eugenic specifications she stipulates? How is this good for children?
3. Should certain women be prohibited from attempting this, i.e. AIDS antibody positive carriers, lesbians? And if so what criteria are to be used?
4. How are married couples protected from deception and paying for a child production service they never actually received in the case where they undergo petri dish fertilization with subsequent implantation for a child they "naturally" conceived?

5. What research is being conducted by the National Institutes of Health that would result in the development of an "artificial womb" for human gestation? If it is being done, under what authority is it carried out, are you prepared to recommend that the Congress halt this?

The above are only a few of the many questions that can be asked because of recent technological innovations affecting human generation.

A measure of how far values and attitudes have come in this area would be legislation prohibiting the practice of "surrogate motherhood". If this could not pass, neither would any proposals dealing with in vitro fertilization -- so far from the norms of the "natural" have we come. Unless the practice of SM could be abolished, there would be no practical chance to abolish IVF for married persons. The Vatican Instruction makes it clear that in countries where the practice of abortion is widespread such efforts at re-establishing the integrity of the marriage bond would be difficult.

But, given the present "realities" of social attitudes being conditioned by a widespread acceptance of artificial birth control, a modest approach would be a bill containing the following provisions and rationale:

Under the Thirteenth Amendment, not only slavery, but the badges and incidences of slavery may be abolished by the Congress. If the situation of "surrogate motherhood" is not a case of child selling and therefore a badge and incidence of slavery, nothing is.

The claim put forth by surrogate motherhood proponents that it is a service, i. e. merely renting a womb, that is being contracted for, it must be asked why such 'contracts' can only be fulfilled with the delivery of a child treated in this case as a chattel?

Accordingly, the U.S. Congress has a duty to abolish such practices within the utilizing the following criteria:

[a.] Agents who procure the services of women for SM should be subject to a fine for the first offence and a fine and or prison sentence for the second.

[b.] No penalty for the prospective SM.

[c.] Procuring or attempting to procure a SM should be an offence with a fine.

[d.] Any SM "contract" should be considered null and void "ab initio" The SM restrictions should apply whether the attempt to procure a baby via SM occurs in the US or abroad. But this restriction should apply only to US citizens.

[e.] Prohibit the interstate advertising of such SM "services".

[f.] The SM prohibitions are to apply only to those artificial insemination techniques [in vitro fertilization and others] regardless of who is the donor of male or female gametes. Conventional adultery or simple fornication would not be covered. Nor would in vitro fertilization of a bona fide married couple be prohibited. However, if a bigamous marriage should be entered into to avoid the SM prohibition, that should come under coverage.

[g.] Child selling is to be prohibited.

[h.] The bill should not cover conventional adoption of children where medical or other incidental expenses are covered for a woman who places her child for adoption.

[i.] Violation of the SM prohibitions should render any physician or institution ineligible for federal funding. Fines and punishments should also apply to such institutions, physicians, and others involved with the prohibited SM in vitro process.

Mr. **Morrison**. I want to thank you all for your testimony. I have a couple of questions. I'd just like to comment at the outset that what distresses me most about this hearing is that activities that are so well developed out there in the world already, are still the source of quite a bit of difference of opinion as to what our public policy approach ought to be.

It seems to me we have a pretty substantial time lag in our willingness and ability to decide what we think and that runs the risk that a lot of interest will grow up around the practices before appropriate levels of government make judgments about these questions.

Mr. Robertson, I was struck by the expansiveness as a believer and practitioner of Constitutional law in my life, I was struck by the expansiveness of your Constitutional analysis. Were you really meaning to say that the procreative right, in your view, the Constitutional parameters of the procreative right really reaches to the point of making, going beyond what the person can really do him or herself, but a right to engage any other person or any other technology in order to realize one's biological destiny?

It seems like a very expansive definition.

Mr. **Robertson**. I did mean to say that. I'm not sure it's as shockingly expansive as perhaps it was experienced when one considers it step by step. After all, with the married couple we certainly allow the married couple to use physicians in child birth and obviously physicians to create conception in in vitro fertilization. That's bringing someone else into it, but of course, you're raising the question about bringing in the third party who provides sperm or egg or surrogacy and my point is that if we take seriously the notion that married couples have a right to procreate, and examine that in the context of when they are infertile and look at the values that underlie the right to procreate, it would seem that those same values would be realized by allowing them to use the assistance of a willing donor or surrogate.

Mr. **Morrison**. When you say the values, what are you understanding to be the values that underlie the Supreme Court's determination of that privacy right to procreate?

Mr. **Robertson**. The right to marry has one of its main purposes as procreation. Secondly, the great importance that procreation has for individual identity and personal fulfillment in marriage. It's those values that would underlie the recognition of a right of procreative liberty by coital and non-coital means.

Mr. **Morrison**. Do you think it's a biology point?

Mr. **Robertson**. Well, it's a——

Mr. **Morrison**. I mean, if it went to the value that was recognized by the Supreme Court, there was ultimately biological.

Mr. **Robertson**. Well, it's rooted in biology, but it obviously has an important social dimension that the purpose or a main function of marriage is a reproductive arrangement. Indeed, society attempts to channel reproduction through marital arrangements.

Mr. **Morrison**. But we're talking about circumstances where reproduction by normal biology doesn't occur.

Mr. **Robertson**. Right.

Mr. **Morrison**. And so, you know, whatever that's about, why ever that occurs, that's the circumstance and now what I'm trying to discover is what value you think it is that the Supreme Court and we all should honor with respect to the Constitution and what that means about what the—I mean, you're basically defining what the State cannot make decisions about——

Mr. ROBERTSON. Right.

Mr. MORRISON [continuing]. Because of the broader decision that's been made in the Constitution to protect some value and I'm trying to find out from you what, exactly, that is and I'm still confused.

Mr. ROBERTSON. It's the same value that is recognized in recognizing the married couple's right to reproduce coitally. Why do we recognize that? Because they're married, they want to reproduce, they want to have a family. Now, the mere fact that by biological accident, the man cannot produce sperm or the woman's tubes are blocked, I don't see why that should deprive the couple of the right to acquire children if there are means available that will allow that to occur, such as the use of a sperm donor or the use of in vitro fertilization.

My point here is that the interests of the couple in forming a family are the same, whether or not they are fertile. They have the same psychological and biological and social interest in forming a family whether or not they are able to do so physically.

Thus, if there are means available to assist them when they cannot do so physically, it would seem that those means should get the same protection that coital reproduction does, especially when those means will lead to offspring biologically related to one of the partners.

Mr. MORRISON. Do you—I think you said something about this, but I'm not sure I caught where you drew this line—do you draw a distinction between what the government will provide financial assistance for and what the government can regulate?

Do you agree with the Supreme Court? Do you agree that the Supreme Court is correct in the *McCray* case about Federal funding versus——

Mr. ROBERTSON. Yes, yes, I do.

Mr. MORRISON. That's a matter of Constitutional law, not as a matter of whether that's the law because that's what they decided.

Mr. ROBERTSON. Right. As a matter of policy, I may disagree with it. I think that is very sound Constitutional law and once the Supreme Court worked through those cases, I think that stands up as a very sound position. Our Constitutional rights are negative rights. They are rights against governmental interference with private choice. They are not positive rights to have the government provide you with——

Mr. MORRISON. That's not what they decided in the First Amendment cases.

Mr. ROBERTSON. I beg to differ with you. I certainly had a right to come here and testify, but I certainly didn't have the right to have the government pay my fare to get here.

Mr. MORRISON. No, but they've decided the subsidy questions differently, I think, in the First Amendment context.

You accept that as the proper bounds? In other words, government support is not what you are talking about. You're just talking about government interference.

Mr. Robertson. Yes. Which seems to me to be the key factor in this area, the people proposing. The Vatican statement says the government should come in and ban all these techniques and my point is, you can't constitutionally.

Mr. Morrison. Ms. Andrews, I was trying to pick up your line of difference with Mr. Annas with respect to the concern about the rights of the third party surrogates, in the surrogate circumstance, the contractors.

Are you satisfied that normal contract law protections are sufficient in these areas to protect the interests that are at stake when somebody enters into these kinds of activities, these kinds of transactions and these kinds of obligations?

Ms. Andrews. I think in most instances, but I would be more comfortable with State legislation clearly setting out who the legal parents are and providing mechanisms to assure the parties and where I differ with Mr. Annas, is in suggesting what shape that State legislation should take.

I think the State legislation should recognize the pre-conception agreements and Mr. Annas is saying that the State legislation should always indicate that the gestational mother is the legal mother, even if she's carrying someone else's embryo.

Mr. Morrison. And I guess I want to understand, why do you think that that is a—from the standpoint of the well-being of the child and social interest, why do you think that that is preferable?

Why will that give us a better outcome?

Ms. Andrews. Because it doesn't leave the children in limbo. I mean, that child when we get back to talking about, as Professor Robertson has, the importance of child bearing in a relationship. The child born to a surrogate mother is only on earth because of the relationship of the couple who had wanted that child. The surrogate hasn't made a decision to have a child as part of her family when she goes into it and so I think we need to recognize that right of the couple.

It's not like an adoption situation. I think the worst situation for the child is to be in litigation and so you have to decide if——

Mr. Morrison. But it's like an adoption in the sense of the decision of the couple that wants the child. They've chosen to get the child to be biologically related to them, which some people think is more important than others, but in any case, that's their decision. But they've still decided that they can't have a child by, I guess what we would call the usual, unassisted fashion, but they want a biologically related child, so they're using a surrogate.

But they've made the decision to have a child, which is very much like a decision to have an adopted child, because they need the assistance of some third party or a series of third parties.

Ms. Andrews. It's not at all like the decision to have an adopted child for the husband whose biological child it is. It's not like an adoption, the woman is pregnant and she has the genetic link to the child, so I think the difference from the viewpoint of the child is that if you say the surrogate could change her mind, that means you're going to have the Baby M case over and over again, because a biological father has a right to contest custody. It's not good for the child, even if the couple who have temporary custody of the child ultimately get it, because of the tension and anxieties of having to go through years of litigation to determine who your legal parents are.

We have to choose one side or the other. I'm in favor of choosing the couple rather than the surrogate, whose husband had not planned on rearing this child.

Mr. **Morrison**. Well, what we choose will determine kind of what behavior will be. I mean, in a sense, picking out a particular dispute where we have failed before the fact to choose the rules of the game, it's a little unfair to pick on that as an example of how things go because I assume people will—because one of the concerns is that people's behavior has been skewed by the way the rules exist.

I guess what I'm trying to understand is, you don't—I guess the concern there is about the surrogate mother's choice at the point of fertilization——

Ms. **Andrews**. I'd like to see massive protections of that choice.

Mr. **Morrison** [continuing]. Is that it is by definition an uninformed choice. I mean, that's the argument on the other side or that it is likely, in many cases, to be an uninformed choice such that the person making it will feel coerced at a later time.

Ms. **Andrews**. I think that really demeans women to suggest that they're incapable of making an informed decision. I prefer to——

Mr. **Morrison**. Well, we make that kind of decision all the time about people being—their state of mind or their state of condition being such that they can't make an informed judgment.

Ms. **Andrews**. But you're doing it here on sex grounds. We don't say that about sperm donors and many sperm donors later feel remorse and would like to see the child.

Mr. **Morrison**. Well, maybe we—I don't really know. I'm not drawing that particular line and if you want to try to develop that line, I'd be very happy to hear it. I'm just getting at where you drew the line and you're not concerned about that.

You believe that we can enforce a set of standards on that contractual decision such that we should then enforce that contract absolutely like we enforce the termination of parental rights against all the world and that we should also allow that to be a compensated—financial transaction as well as an agreement that's binding just without consideration or without any substantial consideration.

Ms. **Andrews**. Sure.

Mr. **Morrison**. That's your position?

Ms. **Andrews**. Yes.

Mr. **Morrison**. And I guess what I'm still asking which I haven't heard yet is, why do you think the decision at that point as opposed to the post-birth point is more protective of the ultimate good of the child, which I assume we have to be concerned about here ultimately, because that's the unprotected party, the one non-adult, non-participant, non-discretionary party.

Ms. **Andrews**. Well, I think that you can't then have a mind change provision unless you say that in all cases where a surrogate changes her mind, she and her husband get the child and there's no question about it, because it's got to go to one couple or the other. I'm just trying to get it out of Court which is the worst possible situation for everybody and which has the parents spending a lot of money they could otherwise spend in important activities raising that child.

So, I think in terms of leaving it open to you as a policy maker, you have to make a choice going in which family does that child belong to. I think since the intentions were for them to belong to the infertile couple's family for whom this may be the only way to get a child, that that's where my policy—I would put policy, but I just don't want it in——

Mr. **Morrison**. Yes, I think of course it's always possible to go to Court, because people can behave in such a way as to force somebody to come and get the child and no matter what rule we make, it will be a rule that ultimately, in some circumstances, will have to be litigated.

Ms. **Andrews**. It's also, you're more likely to get women who will be harmed by this situation if you give them a second chance. Women who aren't certain about whether they can go through with it may get involved with surrogacy thinking they have a second chance.

There's already been one instance in which a surrogate tried to extort more money on the claim that she could change her mind and keep the child. And so, I think I can't say that any of that is really in the child's best interest.

Mr. **Morrison**. I want to give the gentleman from Louisiana—do you have a question?

Mr. **Holloway**. No.

Mr. **Morrison**. We're going to have to close out this hearing. I appreciate that this could—we could do this all day. It's been very interesting and I appreciate your testimony. I must say that from the perspective that I come at some of this, the ease with which the biology triumphs over everything else in these considerations, strikes me as very much something that acts against a lot of our interests in other areas and you're basking your whole Constitutional interpretation of the family integrity line of cases, really concerns me a lot since it comes down to just biology.

Ms. **Andrews**. Well, one thing that should be clarified is that most people who use these techniques would prefer to adopt if that were possible, but they have found barriers, you know, a three to seven year wait, or they're too old or whatever, and so——

Mr. **Morrison**. Or the babies aren't the right color most of all. Let's face the reality, that's what we're talking about more than anything else. There are plenty of healthy, non-white babies available for adoption.

Ms. **Andrews**. Well, you know, part of that is a problem with State law, even in your State, white couples who want black babies aren't allowed to adopt them.

Mr. **Morrison**. I know that, it's—but it seems to me there's a lot going on here that, I mean, I think that some of the testimony received earlier about the underlying causes of some of these problems that haven't got the attention that the high tech solution to the problem gets, is a persistent problem we have on this issue and some others.

I thank you very much for your testimony and the opportunity to hear from you.

The hearing is adjourned.

[The Committee adjourned at 12:57 p.m.]

[Material submitted for inclusion in the record follows:]

A FACT SHEET SUBMITTED BY COMMITTEE MINORITY

IN VITRO FERTILIZATION

Definition

A woman is put on hormonal therapy to stimulate egg production, then her eggs are harvested and fertilized with her husband's sperm (or from a sperm bank donor) in the laboratory. 42 to 78 hours after the laparoscopy, several of the fertilized eggs are returned to the uterus of the original donor or a surrogate mother. In vitro (Latin for "in glass"), once known as test-tube fertilization, is commonly recommended for women with some abnormality or blockage in the fallopian tubes.

4 key methods:

(1) wife's egg can be fertilized by husband's sperm in the petri dish and implanted in the wife (2 parents)

(2) another woman's egg can be fertilized by husband's sperm in the petri dish and implanted in the wife (3 parents)

(3) another woman's egg can ber fertilized by another man's sperm in the petri dish and implanted in the wife (4 parents)

(4) another woman's egg can be fertilized by another man's sperm in the petri dish and implanted in yet another woman, then raised by family that originally desired child (5 parents)

Other key definitions

Embryo: the infant during the 2nd through 8th week after fertilization

Infertility: the inability to fertilize eggs among men is usually due to low sperm count or weak sperm; the inability of women's eggs to become fertilized is most often due to tubal blockage.

Cryoprservation: a method of freezing for later use embryos that remain after an initial implantation attempt (there are many such clinics throughout the country, including Fairfax County) Embryos or sperm are frozen at a temperature of approximately −200 C in liquid nitrogen; when needed they are thawed slowly and transferred into a recipient's uterus.

Laparoscopy: a telescope-like instrument is inserted through a small incision in the patient's abdomen, which enables doctors to see the ova; then a long, thin needle is inserted through a second incision, and ova with surrounding fluid are carefully removed and placed in a laboratory dish (petri dish). (Note: in some cases this does not work and several other new technologies have been developed for these exceptions.)

Test Tube Baby: baby born through in vitro fertilization

Embryo replacement: when the embryo is returned to the donor

Embryo transfer: when the embryo is implanted into a recipient other than the donor of the ovum (i.e. egg)

KEY FACTS ABOUT IN VITRO FERTILIZATION

First baby born using in vitro fertilization was in 1978. Approximately 1000 children have been born since then.

Infertility affects approximately 15% of all married couples in the United States—an estimated 60% due to female infertility and 40% due to male infertility.

Among the reasons for increasing female infertility is delayed childbearing (higher risks of tube blockage after age 30).

Infertility among married women aged 20-24 also increased, by 177% between 1965 and 1982.

Differences of opinion on "success" rate. Most commonly mentioned rates are those given for doctors in IVF programs with "success" rates of 80-90%. That means that while implantation successfully occurs only 20-30% of the time, that by repeating the process 4-5 times, 80-90% eventually are "successful." This rate is similar to natural birth.

3 different super-ovulatory drugs are used to stimulate the production of more than 1 ovum during a cycle (clomid, HCG and pergonal). Many IVF (In Vitro Fertilization) physicians believe that the likelihood of one or more embryos implanting into a uterus increases with the number of embryos replaced, but some limit that to

3 since as many as 15 have reportedly been retrieved and the health hazards of multiple births outweigh the benefits.

The first successful birth of an animal born from an embryo which had been frozen was that of a mouse, reported in 1972 by British scientist Dr. David Whittingham. Since then he has reportedly achieved a successful birth rate of 70% after implanting more than 10,000 mouse embryos which had been frozen. In some cases, the embryos had been frozen for 7 years before being implanted. Follow-up studies of mice born from embryos implanted after 5 years of such storage indicated that these mice and their offspring were normal.

In 1984 two human infants were born from embryos which had been frozen.

30 to 50% of the embryos do not survive the thawing process.

1979 University of Wisconsin survey found that 70% of doctors keep no records of the identities of the sperm donors, so it is not readily possible to identify a donor who has passed on a disease or defect and to cease using him. (Source is Lori Andrews in an August 1984 American Bar Association Journal article. She is a witness at this hearing).

KEY ISSUES OF IN VITRO FERTILIZATION

(1) Should the procedure be performed on humans?

Yes

Affords childless couples the chance to bear children, which they may not otherwise have.

Biomedical science is constantly teaching us new facts about ourselves and biomedical technology is providing us as persons with new capacities to control our environments and to make genetically-transmissible changes in ourselves.

Dr. Leroy Walters: The nature of the technology itself is less important than the social and political uses to which the technology is put. (His argument is that the debate should not be the technology but how some propose to use it.)

Professor Joseph Fletcher: He welcomes the new and artificial modes of reproduction as a much-needed alternative to what he calls the traditional coital-gestational method. He argues that only by employing such new methods will we be able to "end reproductive roulette" and begin to reduce our overwhelming load of genetic defects.

Possible comprehensive national program might work by comparing cards from various tests when marriage licenses are applied for. The couple could unite anyway but on the condition that Denmark makes that sterilization is done for one or both of them. And they could still have children by medical and donor assistance, bypassing their own faulty fertility. (Joseph Fletcher)

No

Replaces conception that originates from a natural intercourse with that of an unnatural origin, conception in a dish outside the body.

Professor Paul Ramsey: "We shall have to assess in vitro fertilization as a long step toward Hatcheries; that is extracorporeal gestation, and the introduction of unlimited genetic changes into human germinal material while it is cultured by the Conditioners and Predestinators of the future."

Vatican document titled "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation:" In vitro fertilization between husband and wife is unacceptable because "even if it is considered in the context of 'de facto' existing sexual relations, the generation of the human person is objectively deprived of its proper perfection: namely, that of being the result and fruit of a conjugal act."

Catholic theologian Michael Novak: The document's main thrust "is to defend a human right never before articulated in such detail and clarity: the human right of a child to be born to two married persons through the mutual gift of their bodily and personal love for one another."

Lutheran theologian Richard John Neuhaus: "I don't think it's the definite word, but it's a marvelously good starting point for discussion . . . it seems to be a limited definition of the act of love but one is challenged to ask, if you expand the act of love to separate love from the act of procreation, then where do you draw the line? It has raised a challenge to all of us to be more precise."

(2) What legal status should an embryo have? Should it have all the legal rights of a human being?

This is especially complicated in view of freezing of embryos for indefinite periods of time.

What provision should be made for embryos in the case where the donors separate or die?

If the donors die, as they did in an Australian plane crash in 1983, and if the embryo is implanted and later delivered, what are the inheritance rights of the child?

(3) Whose child is it?

In 1954 in the Illinois case Doornbos v. Doornbos the court held that even if her husband had consented, a woman who underwent artificial insemination by donor was guilty of adultery. More recent court rulings hold that if a married woman is artificially inseminated with the consent of her husband, the child is the legal child of that couple.

Many state statutes specifically provide that a man is not the legal father if he furnishes sperm for artificial insemination of a woman who is not his wife.

(4) Independence for women

Jane Mattes, a psychotherapist founded Single Mothers by Choice. "Relationships now are disposable. People split. Being a parent is a place to work out intimacy where your partner can't leave."

Women no longer have to settle on a man just because time is running out on their biological clock and single men can seek a surrogate mother if they do not want the entanglements of a wife. (Life magazine cover story; June, 1987)

(5) Who should be responsible for the costs of IVF?

Many researchers believe that the Federal Government, which funds the major portion of all biomedical research in the U.S. should support IVF research.

"Just as there are people who would like to buy a fine car and have to settle for something else, so there are people who cannot afford this."—Dr. Howard Jones, Eastern Medical School in Norfolk

ARTIFICIAL INSEMINATION

Definition

Sperm from an anonymous donor provides a common solution for a male infertility problem. Increasingly, sperm banks are freezing supplies so that, for instance, a couple who want more than one child can go back several years later for a second insemination from the same donor, making their child true siblings.

Key facts

Thousands of births (3576 in 1977) by this method.

95% in one survey were because of male infertility (New England Journal of Medicine, "Current Practice of Artificial Insemination by Donor in the United States," March 15, 1979).

40% of the doctors surveyed have provided this service for reasons other than male sterility however including those husbands who feared transmitting a genetic disease. (NEJ of Medicine).

10% of the doctors in this 1977 survey inseminated single women (NEJ of Medicine).

62% of doctors who selected their own donors for patients used medical students or hospital residents (NEJ of Medicine).

Most doctors attempted to match at least hair color, skin color, eye color and height; more than half also considered religious or ethnic background and blood types. (NEJ of Medicine).

Most doctors who kept track of this information (and fewer doctors answered this question than any other) had never used a donor for more than 6 pregnancies. Approximately 6% had used donors for 15 or more pregnancies. (NEJ of Medicine).

Special problem with this method of birth

Using a single donor for many recipients may result in inadvertent consanguinity or inbreeding. This complication could occur if two people mated who unknowingly shared the same genetic father or if a recipient was inseminated with the semen of a relative. Either may occur accidently, since the identify of the semen donor is almost always concealed.

Confidentiality of donors also raises problems relating to possible future questions relating to adoption, genetic counseling, psychologic needs, and other such questions.

Pro

"'Once upon a time there was a man and a woman. They met, fell in love and married. And very soon they decided to have a family. They made love, and within a year, their first child was born. That one was very soon followed by others. And they lived happily ever after.' THIS IS A FAIRY TALE. For millions of people in America in 1987, it is as patently fantastic as Sleeping Beauty."—*Life* magazine cover story, June, 1987

"Clergy who have talked often of the family as the linchpin of life now say that they want to restrict how families can be created." *Life*, 1987

Procreation is separated from sexual intercourse but in some cases only when the couple has determined that sexual intercourse does not lead to procreation in any case. In these cases, some see the physician functioning as a kind of early midwife, helping the couple with the beginnings of the pregnancy rather than with the delivery of a fully developed fetus.

Con

From "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation":

"The fidelity of the spouses in the unity of marriage involves reciprocal respect of their right to become a father and a mother only through each other."

"Heterlogous artificial fertilization is contrary to the unity of marriage, to the dignity of the spouses, to the vocation proper to parents, and to the child's right to be conceived and brought into the world in marriage and from marriage."

"The fertilization of a married woman with the sperm of a donor different from her husband and fertilization with the husband's sperm of an ovum not coming from his wife are morally illicit. Furthermore, the artificial fertilization of a woman who is unmarried or a widow, whoever the donor may be, cannot be morally justified."

"Homologous artificial fertilization, in seeking a procreation which is not fruit of a specific act of conjugal union, objectively effects an analogous separation between the goods and the meanings of marriage."

"Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: Even when it is done for the purpose of procreation the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely the relationship which realizes the full sense of mutual self-giving and human procreation in the context of true love.'"

SURROGATE MOTHERHOOD

Definition

A surrogate motherhood arrangement generally involves a couple that is infertile or otherwise unable or unwilling to bear a child, and a woman, contracted by the couple to bear the child for them.

In the process, a woman, or surrogate, is impregnated by the semen of a man who is not her husband and agrees to turn over the child born as a result of that action to the child's father and his wife. Although circumstances of particular cases can vary, the parties generally sign a contract setting out their various rights and responsibilities, under which the surrogate mother agrees to relinquish all rights to the child after birth, in exchange for a fee (typically $10,000) and payment of all legal and medical expenses. The father's wife is not usually party to this contract, to avoid possible violation and prohibitions against "baby selling," but goes on to legally adopt the child as her own, after her husband's paternity has been established. Following this action, unless otherwise provided by contract, the surrogate mother has no legal right to further contact with the child.

Other types of surrogate mothering arrangements exist, such as those between a surrogate and a single male, an unmarried couple or a single woman who can not or will not carry the child and does not want the burden of a spouse. For the most part, however, surrogate arrangements involve a couple and a woman to act as a surrogate.

> The use of the term "surrogate" for a woman who is the genetic and gestational mother of a child appears a misnomer to those who feel that the adoptive mother is actually the surrogate for the biologic mother, who has given up her child.

Specifics of the process and contracting procedure

When the wife has been determined to be infertile (or has problems that preclude pregnancy) and generally after other methods of fertilization have been exhausted, the couple may seek legal and medical advice for an arrangement with a surrogate mother. A lawyer is charged with finding a surrogate and preparing the legal documents for the procedure. Generally, these documents arrange payment of the surrogate and clarify that in return she must turn over the child and all further responsibility and legal right to the child. It further provides that the father has the right to demand that the mother undergo amniocentisis to determine if the fetus is deformed, and can insist that the mother have an abortion based on the results of the test. While financial arrangements may vary, most set out a schedule of payments should the mother miscarry or give birth to a stillborn child, in addition to the payment of all medical and legal expenses. The father is usually thought obligated to accept a physically or mentally deformed child, although this may not be specifically spelled out in the contract.

After a series of tests, the surrogate mother is artifically inseminated with the semen of the contracting husband. By contract, the mother is bound not to have sex with anyone during this process until her pregnancy is confirmed. Her actions, eating and drinking habits, and other aspects of her personal life are controlled by the contract and the father may disclaim responsibility or default on the contract subject to the mother's observance of the contractual obligations.

After the birth of the child and the determination of its health, the mother has a certain period (depending on the contract and the state law) in which she may reconsider surrendering the child. Once she decides to relinquish responsibility for the infant and the father's paternity is established, the process of adoption by the father's wife may take place, thus the couple takes the child as their own.

KEY FACTS ABOUT SURROGATE MOTHERING

An estimated 600 surragocies have taken place in the United States to date.

Artificial insemination is the closest process to surrogate mothering for which there is legal precedent in the United States.

Often, surrogate mother arrangements are handled informally, where all parties know each other (e.g., a women decides to bear a child for her infertile sister). These operate completely outside of the law with regard to such matters as which names go on the birth certificate, the need for adoption and the termination of parental rights and financial and other obligations.

DEMOGRAPHICS OF SURROGATE MOTHERS

Surrogate mothers average 25 years of age.
More than 50% of surrogate mothers are married.
One fifth of surrogate mothers are divorced.
One fourth of surrogate mothers are single.
57% of surrogate mothers are Protestant.
42% of surrogate mothers are Catholic.
One half of surrogate mothers are high school graduates.
One fourth of surrogate mothers have schooling beyond high school.

The "Baby M" Case and its legal and ethical considerations

In the well publicized *Baby M* case, Mary Beth Whitehead entered into a standard surrogate parenting agreement in Febraury 1985, under which Mrs. Whitehead was to receive $10,000 for giving birth to a full term baby. Ricahard Whitehead, Mrs. Whitehead's husband, acknowledged that he refused to consent to the artificial insemination of the child born to his wife, so that he was not to be considered the father of the child born to his wife. Mrs. Stern, the prospective adoptive mother, was not party to the contract to insure that no prohibitions against baby selling or the payment of money in connection with the adoption, were violated. When the child was born in March of 1986, Mr. and Mrs. Whitehead signed an acknowledgement of Mr. Stern's paternity.

Mrs. Whitehead became despondent after turning over the child and gained the Stern's permission to see the child for a week. Rather than returning the child to the contracting parents, she fled to Florida with the child for several months.

The court's decision

In the New Jersey Supreme Court, Judge Harvey Sorkow upheld the contract as valid, terminated Mrs. Whitehead's parental rights and awarded custody of the child to the Sterns, allowing Mrs. Stern to adopt the baby. Had he ruled the contract invalid, the case would have reverted to a standard custody case in which the decision between parents is based on "the best interest of the child." In his decision, Judge Sorkow clearly found that the baby's best interests would be met by the Sterns. He found that the Sterns would provide a loving environment and opportunity for higher education. The judge further cited Mrs. Whitehead's implusive behavior, including threats to kill the child rather than return it to the Sterns, the claim that the child was her husband's, despite his vasectomy some years previously, and her removal of her son from public school without even notifying his teachers when they fled to Florida.

Concerns noted in the decision

1. That the child will not be protected.
2. The potential for exploitation of the surrogate.
3. The alleged denigration of human dignity by recognizing any agreement in which a child is produced for money.
4. The undermining of traditional notions of family.
5. Surrogacy allows an elite economic group to use a poorer group of people to achieve their purposes.

The court's rejection of noted concerns

1. Whether or not there is compliance with the contract, the child will be protected. In compliance, the child will be adopted with inquiry into its well being. If there is not compliance, the child's well being will still be litigated by the court.
2. Surrogate mothering is not as exploitative as private adoption, where a woman who is already pregnant may be forced to take action (such as giving up her child) that she would rather avoid. In surrogacy, the contract is made before pregnancy, when the desire and the intention to have a family exists on the couple's part and the surrogate has an opportunity to consult, take advice and consider her act and is not forced into the relationship.
3. Money paid to the surrogate is not being paid for the surrender of a child; rather the biological father pays the surrogate for her willingness to be impregnated and carry his child. This is not baby selling in that the father can not buy what is already his.
4. Surrogate motherhood cannot undermine traditional notions of the family since the whole purpose of the arrangement is to create a family, and it may be the only way to do so for childless couples who very much want one.
5. The judge found this argument "insensitive and offensive to the intensive drive to procreate naturally and when that is impossible to use what lawful means as possible to gain a child"—a fundamental desire of all men and women, regardless of economic status.

Specific cases and problems concerning surrogate mothering

In some cases, such as those in which the child is born with a defect, neither party wishes custody of the child. In such a case, a child born to a surogate was diagnosed as having microcephaly, a condition related to mental retardation. The contracting man claimed that the baby was not his and thus he was not obligated to either take the baby or pay the surrogate's fee. On the basis of blood typing, it was determined that the baby was not in fact the contracting man's and that the surrogate had become pregnant by her husband before the artificial insemination, thus the surrogate and her husband resumed responsibility for the child.

In the Kentucky Supreme Court, a decision was reached that the State's prohibition of purchasing a child for the purpose of adoption did not apply in a surrogate mothering case where the agreement to turn over the child is entered before the child is conceived. The court provided surrogate mothers 5 days from the birth of the child to reconsider their decision to turn over the child. This law takes precedence over the contractural obligation to turn the child over. Should the mother decide not to relinquish the child, she would receive none of the money promised to her, but the biological father would be placed in the same position of responsibility as any other father with a child born out of wedlock.

In the Michigan case of *Doe V. Kelley*, a couple challenged the constitutionality of several adoption statutes which prohibited them from entering a surrogate mothering contract. The laws concerned prohibited the exchange of money in connection with adoption related proceedings. The court found that the couple's desire to change the legal status of the child born of the surrogate through use of the adoption code not to be "within the realm of fundamental interests protected by the right to privacy from reasonable government regulation." However, it also held that the challenged laws did not prohibit the couple from having the child as planned.

Pro

"Collaborative reproduction allows some persons who might otherwise remain childless to produce healthy children."

"For couples exhausted and frustrated by these efforts [to adopt a child the surrogate arrangement seems a godsend."

"While this price tag [$20,000 to $25,000] makes the surrogate contract a consumption item for the middle classes, it is not unjust to poor couples for it does not leave them worse off than they were."

"If you estimate 600 to date, the percentage of problems is very, very small. This is the last alternative for many people. They have already gone through surgery, in vitro fertilization, an adoption attempt. They know there are not enough adoptable babies. They feel very lucky that there is one more alternative." LIFE p. 25.

"For the child, the use of a surrogate mother gives him or her an opportunity that would not otherwise be available: the opportunity to exist. Furthermore, the child would be reared by a couple who so wanted him or her that they were willing to participate in a novel process with potential legal and other risks."

Con

"Surrogate motherhood is partly like indentured servitude and partly like prostitution. Like prostitution, it makes one of the most intimate acts a commercial, and therefore, impersonal, transaction. Like indentured servitude, it permits an individual to sell, not just the fruits of his labor, but his personal authonmy." NR

"In exalting promiscuity to the level of monogamy, and reducing motherhood to a 'service,' we pander to the weakest side of our natures and punish what is best in us."

'However, its [surrogate mothering's deliberate separation of genetic, gestational, and social parentage is troublesome. . . there is a risk of confusing family lineage and personal identity. In addition, the techniques intentionally manipulate a natural process that many persons want free of technical intervention."

'Surrogate mother arrangements are designed to separate in the mind of the surrogate mother the decision to create a child from the decision to have and raise that child. The cause of this dissociation is some other benefit that she will receive, most often money. In other words, her desire to create a child is born of some motive other than the desire to become a parent. This separation of the decision to create a child from the decision to parent it is ethically suspect. The child is conceived not because he is wanted by his biological mother, but because he can be useful to someone else. He is conceived in order to be given away."

Alternative Methods of Surrogacy

Host womb surrogacy

It is now possible to fertilize an egg outside of the body through in vitro fertilization, and use the resultant embryo to impregnate a surrogate mother if the biological mother for some reason cannot carry a child. Also, embryo transplants may in time make it possible for women with histories of early miscarriages to become pregnant, after which the embryo is moved to the womb of another woman who carries and gives birth to the child.

> The world's first 'host womb" baby (the mother's egg was fertilized in vitro by the father's sperm and implanted into the womb of a third woman) recently turned one year old.

"What is technically possible is not for that very reason morally admissable."

Fetal research is essential to the development of new therapies and treatments for what are now devastating, even fatal, diseases and disorders. Advances such as treatment for Rh disease and in utero surgery for defects such as hydrocephalus are only possible through research involving the fetus. Great care was taken in writing the current regulations to ensure that no harm comes to any fetus or infant as a result of research efforts.

In 1985 the Health Research Extension Act improved protections for the human subject in fetal experimentation and imposed a three year moratorium on any waiver of such protections by the Secretary of HHS. A waiver would only be necessary if one wished to authorize unethical experiments—those which subject an individual human being to risk of harm or death solely to gain knowledge for the benefit of others. When the moratorium expires in 1988 pro-life forces will urge Congress to bar such waivers permanently.

Definitions

Research.—any inductive-deductive process which aims at promoting the systematic observation of a given phenomenon in the human field or at verifying at hypothesis arising from previous observations.

Experimentation.—any research in which the human being (in the various stages of his existence: embryo, fetus, child or adult) represents the object through which or upon which one intends to verify the effect, at present unknown or not sufficiently known, of a given treatment (e.g., pharmacological teratogenic, surgical, etc.).

Should research on human embryos be permitted?

Proponents: Research on embryos should be allowed in order to gain knowledge which could be aimed, not only at improving the success rate of in vitro fertilization, but also increasing researcher's understanding about the early stages of human development (Irene-Stith-Coleman, Analyst in Life Sciences, Science Policy Research Division, Congressional Research Service, April 12, 1985).

Opponents: It would be unethical to experiment on human embryos because, to do so, is to tamper with human life, which is viewed as sacred. Opponents also fear that scientists may potentially use the knowledge obtained from research on human embryos to produce people with selective physical and mental characteristics (Irene Stith-Coleman, Analyst in Life Sciences, Science Policy Research Division, Congressional Research Service, April 12, 1985).

The Law of the New Reproductive Technologies (Lori B. Andrews, "The Stork Market: The Law of the New Reproductive Technologies," American Bar Association Journal, Vol. 70, August 1984)

Not all the new conceptions are yet available in every state due to restrictive state laws on fetal research and adoption.

In the wake of the U.S. Supreme Court's 1973 decision regarding abortion, *Roe* v. *Wade*, 410 U.S. 113 (1973), numerous state legislatures felt that in order to maintain respect for human dignity, it was necessary to pass laws restricting or banning research on fetuses.

Many of the state laws explicitly define the term fetus to include an embryo or any product of conception.

To the extent the IVF, embryo transfer or embryo freezing are considered experimental and provide no clear and immediate therapeutic benefit to the embryo, the fetal research laws may present obstacles to the use of these infertility treatments.

Of the 25 states with fetal research laws, 14 cover research only when it is done at a time when abortion is anticipated or subsequent to an abortion. Others cover only research with a fetus that exhibits a heartbeat, spontaneous voluntary muscle movement or pulsation of the umbilical cord.

Laws of these two types would not cover in vitro fertilization because the procedure does not involve abortion and, by the time the fetus exhibits the capabilities mentioned, it is no longer part of ex utero research but rather developing in utero in the course of a normal pregnancy.

Laws that ban research on fetuses in a more general manner, however, might preclude the practice of IVF.

The laws restricting fetal research present an even greater barrier to embryo transfer, potentially prohibiting the process in at least 16 states.

A greater number of statutes would extent regulation to this procedure rather than IVF because many of these laws prohibit fetal research in connection with an abortion. Under most of these laws the definition of abortion would seem to encompass the flushing technique used in embryo transfer.

The fetal research laws are also broad enough in some states to put restraints on a woman whose ovum are fertilized and transferred.

Laws in five states prohibit a woman from selling a fetus for experimentation. In an additional nine states statutes reach even women who merely give away or permit someone to use a live fetus.

Moral Evaluation of Research & Experimentation on Human Embryos & Fetuses ("Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation," Origins, Vol. 16: No. 40, 3/19/87)

Medical research must refrain from operations on live embryos, unless there is a moral certainty of not causing harm to the life or integrity of the unborn child and mother, and on condition that the parents have given their free and informed consent to the procedure.

If follows that all research, even when limited to the simple observation of the embryo, would become illicit were it to involve risk to the embryo's physical integrity or life by reason of the methods used or the effects induced.

If the embryos are living, whether viable or not, they must be respected just like any human person; experimentation on embryos which is not directly therapeutic is illicit.

No objective, even though noble in itself such as a foreseeable advantage to science, to other human beings or to society, can in any way justify experimentation on living human embryos or fetuses, whether viable or not, either inside or outside the mother's womb. The informed consent ordinarily required for clinical experimentation on adults cannot be granted by the parents, who may not freely dispose of the physical integrity or life of the unborn child. Moreover, experimentation on embryos and fetuses always involves the certain expectation of harm to their physical integrity or even their death.

To use human embryos or fetuses as the object or instrument of experimentation constitutes a crime against their dignity as human beings having a right to the same respect that is due to the child already born and to every human person.

It is immoral to produce human embryos destined to be exploited as disposable "biological material."

It is a duty to condemn the particular gravity of the voluntary destruction of human embryos obtained "in vitro" for the sole purpose of research, either by means of artificial insemination or by means of "twin fission."

It is therefore not in conformity with the moral law deliberately to expose to death human embryos obtained "in vitor."

In consequence of the fact that they have been produced in vitro, those embryos which are not transferred into the body of the mother and are called "spare" are exposed to an absurd fate, with no possibility of their being offered safe means of survival which can be licitly pursued.

AMNIOCENTISIS AND ULTRASOUND

Prenatal diagnosis of the baby's expected condition.

Pro

It is claimed that some children are now born healthy because doctors can judge when and how to deliver and arrange for pediatric surgeons to be present in the delivery room, ready to perform immediate procedures.

Con

It is claimed that the methods are primarily used to identify unwanted children so that they can be aborted.

"The most advanced machines now provide images good enough that pregnant women often stare in amazed delight at the screen, waving and talking to their fetuses as they roll and kick before their eyes. The machine, however, requires an educated, practiced eye to sort out the blured gray shapes and understand what they mean."—from *Los Angeles Times* article by Barry Siegel.

He knew his burden. To conclude whether a thumbnail-size heart was normal probably would decide the fetus' fate and effect the parents in unknown ways. If someone is going to terminate a pregnancy based on my diagnosis, he told himself, I'm going to be sure. But then he thought: We're not perfect. We're not God." " 'I feel uncomfortable to a degree,' he said slowly, choosing each word with care. 'But not so uncomfortable as to change what I do here . . . There is a recognition that we aren't perfect, that our attempts to improve people's lives do a fair amount of good and also cause problems.' "—*LA Times*

"A couple's firstborn suffered from a particular type of mental retardation and organ malformation that was marked physically by small dysplastic fingernails. During the second pregnancy, the doctors were asked to examine the fetus.

"It was, as always, a judgment call. They had limited experience then, and the few other cases they had seen had been during varying points of gestation. Still, they both agree that it seemed like the fingernails were malformed. The fetus looked afflicted. "The family decided to terminate. Afterward, the doctor studied the tiny abortus. Try as he might, he could not convince himself that the fingernails were abnormal. Nor could the other doctors."—*LA Times*

TWO OTHER CONTROVERSIAL ISSUES

Parenting Desires Among Bisexual Women & Lesbians

Question. During the time you have thought yourself a lesbian or bisexual, have you considered having children? If so, by which methods?

[In percent]

	Bisexual women	Lesbians
Donor insemination	38	61
Adoption	53	62
Intercourse with cooperative man	65	37
Intercourse with unsuspecting man	22	15

Among those who had sucessfully had children, more lesbians were successful through donor insemination while more bisexual women were successful through intercourse with a cooperative man.

Source, Journal of Reproductive Medicine, March 1987.

Science versus Values

Dr. Leroy Walters: On a theoretical level, science and values cannot possibly conflict because they involve two different enterprises. Science is the development of information by abstracting out certain things and looking at little segments of reality, at smaller and smaller pieces. It's usually an analytical enterprise that seeks to develop factual information and knowledge. It supplies some of the raw material on which we then base our value judgment.

Response from Dr. Moraczewski: Science ordinarily, as we understand it, is concerned with understanding of how something came to be, how it functions, whether that something is inanimate in nature. On the other hand, technology is concerned with controlling and modifying that nature. In contrast human values originate from reflection on a different scale, some from a philosophical reflection and some from religious considerations, but they pertain to man as man and not as scientific enterprise. So there is potential conflict . . . who will determine the social and political priorities from the genetic future? Will it be a group of scientists and doctors speaking for the public interest? of a politically minded few?

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May 19, 1987

Select Committee on Child Youth & Family
35 House Annex 2
Washington, D.C. 20515

Pursuant to our conversation, I am herewith enclosing for your information, copies of my testimony before both the New York State and New Jersey Legislatures regarding Commercial Surrogacy and the problems in Commercial Surrogacy. There is other information which I would be pleasedto provide your Committee with if you would like same.

Please note that I presently Co-chair the New York State Bar Association Family Law Section Committee on Surrogate Parenting and Chair the American Academy of Matrimonial Lawyers-New York Chapter Committee on Surrogate Parenting. I am Counsel Member of the American Bar Associations Family Law Section as well. If there is any input I can give your Committee, please feel free to call upon me.

Very truly yours,
Robert D. Arenstein
Robert D. Arenstein

RDA/rc
enc.

A FACT SHEET SUBMITTED BY COMMITTEE MINORITY

PREPARED STATEMENT OF ROBERT D. ARENSTEIN, CHAIR, THE SURROGATE PARENTING COMMITTEE OF THE AMERICAN ACADEMY OF MATRIMONIAL LAWYERS, NEW YORK CHAPTER AND CO-CHAIR THE SURROGATE PARENTING COMMITTEE OF THE NEW YORK STATE BAR FAMILY LAW SECTION, AND MEMBER OF NEW JERSEY BAR, STATE OF NEW JERSEY

I appreciate the opportunity to appear before you today to express my views regarding the issues of Surrogate Parenting and Alternate Reproduction. I presently Chair the Surrogate Parenting Committee of the American Academy of Matrimonial Lawyers, New York Chapter and Co-Chair the Surrogate Parenting Committee of the New York State Bar Family Law Section. I am also a member of the New Jersey Bar and a resident of the State of New Jersey. I was also one of the former attorneys representing Mary Beth Whitehead. We have been studying this area in our Committees in New York and have made recommendations which are in the process of being disseminated to our executive committees. I stress that the opinions and recommendations that I will make today are those of my own personal experience and do not represent the conclusion of the Committee. These recommendations will be made officially at a later date.

I have had the opportunity to review Bills A-3035, A-3036, A-3037, A-3038, A-3039 A-3040 and AJR-76. As part of my testimony I plan to comment on these Bills and expand my views to cover the entire issue of Surrogate Parenting in the State of New Jersey.

There are many ways in which childless couples can seek to have children, the most prevalent way in our country is that of adoption. Our State and all of our sister States have devised laws to protect all parties in the adoption area. There are many people who would say that there are not enough children in the adoption process to aid and help childless couples obtain children. In fact, they argue that it takes a very long time for a couple to adopt a child and that many people, as a result of age, religion, sexual preference and otherwise, have been denied the right to adopt. There may be reasons why these roadblocks have been placed in the adoption process. A closer examination of the adoption process in our State may be in order.

To look at the issue of Surrogate Parenting and the present Bills which are before you, raises many questions and problems in my mind. I do not believe that Surrogate Parenting is a concept which is viable in today's society. I have said on a prior occasions that I consider it to be a form of reproductive prostitution and that it contravenes the prohibitions against buying and selling babies. Further, many nations in the world have found that Surrogate Parenting should be outlawed and have taken steps to outlaw the practice before it becomes wide spread.

Britain, as a result of the Warnock Commission Report, has banned commercial surrogacy and the issue has provoked vigorous national debate. Nevertheless, four (4) countries, West Germany, Norway, Sweden and the Netherlands are considering surrogacy bans and the West European Justice Ministers are to discuss the issues at a conference on artificial reproduction scheduled this week in Brussels. The European consensus against U.S. style agencies that arrange for childless couples to bear babies was quoted by Frits Hondius, Deputy Director of Legal Affairs for the 21 Nation Counsel of Europe, in which he said, "...In Europe, I think there is a general feeling that whatever you allow it should not be for profit. It should be done out of compassion..."

At the present time, among the Western European Countries, only Britain has specifically banned commerical surrogacy. The British Parliament passed a law in 1985, after a court granted a couple, believed to be Americans, custody of a baby born as a result of a deal arranged through a surrogacy agency.

Because of the uncertainty over whether the law covered private surrogacy deals, the government brought a test case this year concerning a couple who wanted to adopt a two (2) year old girl, whom a surrogate mother privately bore for them, for $8,000.00. On March 11, a high court ruled in the couples favor, saying the child was thriving under their care and noting that the surrogate mother had no objection.

The next day, another high court, ruled in a case strikingly similar to the Baby M case in New Jersey, granting custody to the surrogate mother who bore twins for a childless couple for an unspecified fee and then changed her mind about giving them up. The Judge, in that case, said the maternal bond between the woman who, with her other five (5) year old child was on Social Security, outweighed the intellectual quality and environment of the childless couples home.

The West German Health Minister, Rita Suessmuth, said in January that she would introduce a Bill in Parliament this year, banning surrogate births and advertisements dealing with them. A similar bill is expected to be approved by the Norwegian Parliament this Spring.

In Sweden and France, surrogacy is prohibited under Adoption Regulations but a Swedish Government appointed inquiry has proposed legislation banning surrogacy as "a doubtful bargaining with children". Although surrogacy is not seen as a major issue in the Netherlands, the Dutch Health Council, a Government Advisory Body, has called for a ban on surrogacy agencies to prevent the practice from becoming a commercial gimmick. In Switzerland, there is a bid for a national referendum on genetic engineering that would ban commerical surrogacy. Under Swiss law, it would be several years before such a referendum could come to a vote. Israel has banned surrogate parenting as well.

The Vatican has strongly condemned surrogacy in a pronouncement in March of this year.

The reports of Waller and Demack in Australia and the Warnock Commission in England all reach the same conclusion with respect to surrogate motherhood arrangements in any form, they recommend that it should be made illegal to:

(a) advertise to recruit surrogate mothers
(b) exchange money as a result of the contract
and that (c) Surrogate contracts should be treated as null and void and unenforceable as contrary to public policy.

The basic premise in the legislative intent of Assembly Bill 3038 is to facilitate the ability of infertile married couples to become parents through the use of surrogate mothers. A State may not prohibit the practice of surrogate parenting or enact regulations that would have the effect of prohibiting the practice. The right to bear and beget a child is protected but not necessarily the right to contract. The thrust of the European arguments, I believe, is that commercial surrogacy through infertility centers which are springing up throughout the country, can and should be banned. The altruistic act of somebody who is involved in surrogacy may be for different motivation, but it is clear to me that the infertility centers across the country are profit making ventures, evidenced by the large non-refundable fees, which are charged by these clinics.

The Supreme Court of the United States has recognized, on numerous occasions, that the relationship between parent and child is constitutionally protected.

There is a fundamental liberty interest of natural parents in the care, custody and management of their child, which is protected by the 14th Amendment. The court has repeatedly emphasized the importance of the family in our society. It has been said that the interest of a parent in the companionship care, custody and management of his or her child "occupies a unique place in our legal culture, given the centrality of family life as a focus for personal meaning and responsibility. Far more precious than property rights, parental rights have been deemed to be among those essential to the orderly presence of happiness by free men. It should be more significant and priceless than liberties which derive merely from shifting economic arrangments.

In addition to protecting the interest of the child born of the surrogate arrangement, the state also has a duty to protect the other children who will be irreparably damaged by the enforcement of surrogate parenting agreements. Physicians artificially inseminating surrogate mothers usually prefer that the mothers already have one or two healthy children of their own. This is to help assure the likelihood of a normal, healthy newborn. The psychological implication of watching a mother's pregnancy terminate with the giving away, or worse yet, the selling of an offspring can be disasterous. The siblings of the surrogate child will wonder if they are soon to suffer the same fate, being taken away from their mother for some incomprehensible reason. No one has considered the unbearable guilt reaction that this child will face when later in life they learn that their sister was carried and sold for funds that were put aside for their education or welfare.

Equally serious, are the symptoms of guilt frequently seen among siblings of a deceased or seriously injured child. Siblings frequently allow a normal degree of jealousy to appear as wishes of death or illness upon a brother, sister or unborn sibling. It is a well known fact that in cases of death of a sibling, the surviving brothers and sisters assume that the fault for the death was theirs, because of these jealous wishes. This jealousy is frequently apparent as a child watches his mother undergo changes as she becomes pregnant. These guilt reactions when the sibling is mysteriously taken away are likely to cause a guilt complex of devastating and long lasting proportions. These facts must be considered.

The Bills, which this Committee is presently considering, have many flaws. To begin with, the parties are still left to make a contract, which would include financial compensation both to the surrogate mother involved and to the infertility centers or baby brokers which broker the arrangement. After a careful examination of this bill, I do find lacking strict regulations regarding the baby brokers to prevent the commercial exploitation of both the infertile couples and the surrogate mothers who are involved in the process. When the parties are satisfied, the process is fine. However, when one of the parties has a problem, be it the mother, the father or either spouse, the only people to profit from that problem are the brokers. Our State has strict regulations on hospitals and medical care. Yet, when it comes to the selling or the purchase of a child, we do not propose to supervise the brokers involved in the process and I find that to be surprising. Certainly the Bill includes a provision for independent mental health care professionals to be involved in the process, but the policing of the people involved in profiting from the sale, need to be addressed in A-3038.

Additionally, I find various constitutional problems with the A-3038 itself. There is no definition of infertility, and limiting the Bill to infertilite couples, might raise a discrimination problem of constitutional proportions. Can you legitimately discriminate if you allow surrogate parenting only to the infertile? Is being sterile voluntary or in voluntary, infertility? Will you let a person who voluntarily becomes sterile use the process. Furthermore, the term child, does it include a stillborn or miscarried embryo or would it apply only to that of only a fully born fetus. This may create a substantial problem in the woman who is engaged in the reproductive process but does not fully deliver a product, namely, a human being. Many of the agreements which have been used heretofore by the infertility centers diminish payment as a result of any defective product which is produced by a surrogate mother. This bill does not address that issue and leaves it to the parties.

Prior to a recent meeting of the Surrogate Parenting Committee of the New York State Bar, Family Law Section, I received a letter from one of my Co-Chairs, Bruno Colapietro, a distinguished matrimonial lawyer in Binghamton, New York. I would like to read to you his comments regarding surrogate parenting as I find them to be relevant and important to this forum. This is a letter dated April 1, 1987, and I quote:

> "...Confirming our telephone conversation of March 31, 1987, I am waiting to confirm my views in opposition to the Dunne, Goodhue bill.
>
> I feel that contracts for surrogate parenting are both illegal and immoral.
>
> We know that we cannot go to a woman and "buy" her baby and place it for adoption no matter how worthy the adoptive parents are and no matter how willing the natural mother is. The distinction between this and a surrogate parenting contract eludes me.

> One of my strong feelings on this is that people with money will be dealing with people who need money. I do not think you will find parents who are less affluent dealing with a wealthy mother in order to procure a child. It is unnatural for a mother to surrender her child. My experience has been that when she does give up her child, it is done out of an act of love or necessity--a feeling that what she is doing is in the best interest of the child because no viable alternative exists.
>
> If you put it on a commercial level you are placing the natural mother in a position where she must learn to condition herself to the point where she does not give a damn about the child, only the money. This is unnatural and I do not want to think somewhere down the road we have a generation of mother's who bore children they did not care anything about.
>
> I also feel that you end up with cases like Baby M where it is a tragedy for all concerned, especially the child. ..."

In addition, the A-3038 Bill which allows a court to terminate the rights of a mother at the birth of the child, leads to grave constitutional implications, in my opinion. To begin with, there are no statutes in the country at the present time which allow a pre-birth termination of maternal rights to be enforced after the birth of a child with an afterbirth ratification of the birth mother. The standard used in most States for termination of parental rights is a clear and unequivocable standard and the right to family integrity has been held to be a fundamental liberty and subject to a higher standard necessary by the court because of the conclusion that the right to a family integrity is a fundamental right. The U.S. Supreme Court, while never expressly declaring the right to be a parent to be an absolute and fundamental right has nonetheless implied that the right to family integrity is indeed fundamental and the court has generally found such a right on the basis of one of two tests, (1) a liberty test and, (2) privacy interest. The theory that there exists a liberty interest in one's family is articulated in Meyer v. Nebraska, where the court held that the 14th Amendment includes the right of the individual to marry, establish a home and bring up children. Again, in the case of Pierce v. Society of Sisters, the court found that the State may not interfere with the liberty of parents to direct the upbringing and education of children. This language suggests the rights of parents in matters concerning their children is certainly to be highly regarded and not easily interfered with.

Under the privacy rational, the Supreme Court has also intimated the right to family integrity as an important interest and in the case of Roe v. Wade, the court recognized an individuals right to privacy interest in such matters as marriage, procreation, contraception, family relationships and child rearing and education. In Griswold v. Connecticut, the court upheld the privacy interests of a couple wishing to use birth control. The courts have found that the right to associate with one's immediate family is a fundamental liberty protected by the State and Federal Constitutions. Because the court finds a fundamental right is involved, the strict scrutiny standard must be the standard of review. The strict scrutiny standard requires a compelling state interest to serve by legislation in any proposed statute and that there be no less onerous alternative available to achieve the statutory objective. Termination statutes across the country are generally used only when there is abandonment, abuse and neglect. In effect, the legislation, we address today, would allow a termination of parental rights prior to or at the birth of a child without giving the birth mother a right to change her mind after birth. Informed consent, clearly means more than simple knowledge of the terms and conditions of the agreement, may not intelligently be given by a birth mother until after the birth of the child and that is why the adoption statutes in this country have required an informed consent after the birth of the child. There is no statute in this country, which allows a pre-birth termination to be upheld without a ratification after the birth of the child. There must be a right for a birth mother to make an informed consent after the birth of a child. I would suggest that issue be addressed.

I further alluded to the commercialism of surrogacy in this country and I believe that if you limit payment to the medical expenses and maternity expenses of the mother, that you will not have only the middle and lower class women be the ones who will volunteer themselves for surrogacy. Have any of you ever seen a wealthy surrogate mother? I have never seen one. I am sure there are some whose altruistic beliefs in helping an infertile couple will certainly be in the forefront if one were so much in favor of this concept.

I found interesting a letter to the Editor in the Newark Star Ledger, regarding the Baby M case and surrogacy in general. The letter posed four (4) questions to the readers of the newspaper which I would like to read to this Committee as I find they are very relevant to the discussion on surrogate parenting.

To begin with the questions read:

> Should the surrogate agencies be allowed to discriminate on the basis of race when choosing a surrogate mother, thus depriving minority women of this economic opportunity?
>
> Should surrogate mothers be paid the minimum wage for their services?
>
> Should people who receive surrogate babies be required to pay the state sales tax when paying for the service?
>
> Should a surrogate mother be entitled to collect unemployment after the baby is born since her employment terminates with the birth of the baby?

I believe these questions raise other questions which this panel may want to address to other witnesses in your search for a fair minded Bill.

An interesting decision in the State of Indiana, County of Marion, Superior Court by the Honorable Victor S. Pfau in October of 1986, which the Judge examined a surrogate parenting contract. The Judge found "(1) that the surrogate contract is contrary to Indiana Law inasmuch as it contains provisions for payment of money to the surrogate mother in connection with the pending adoption proceedings, which payments are over and above those allowed by statute for hospital and medical expenses and reasonable attorney's fees, which expenses need not be approved by the courts who arise in the adoption; (2) The surrogate contract is also contrary to public policy prohibiting the exploitation of needy women, baby selling, disruption of national bonds between the biological mother and child, and it encourages surrogates to have babies they do not want. The contract promotes commercialism in this area and is contrary to the minor child's best interests inasmuch as it promotes the conception of illegitimate children and could effect the minor child's right to inherit, custody and support. I noticed that this Bill would put intact the inheritance rights to the intended couple and would cut off any inheritance rights from the natural mother.

The abuse which occurs in the commercialism of surrogate parenting, is evident throughout the country. Various lawsuits against infertility centers have errupted as a result of the profit and money making, one could make in this field. One woman was induced to become a surrogate after five (5) miscarriages and nine (9) pregnancies and having her cervix partly removed. The surrogate in that case went into shock after an improper artificial insemination and delivered a premature baby who died shortly after birth. When she tried to collect her fee, it was refused to her. Finally this woman, who was initially refused her compensation, received a partial compensation seven (7) months after the baby died.

As you can see, I am strongly against surrogate parenting at least in a commercial setting. In Vitro fertilization would be a better place to develop this concept, then the present form of surrogate mothering. However, if after all the discussions both pro and con, the Legislature still feels that surrogate parenting should be permitted, I have some specific proposals which I believe should have been adopted for legislation in this area.

I would suggest that any Bill to be considered contain the following elements:

1. A period of time after the child is born for the biological mother to change her mind with regard to the agreement.

2. Psychological counseling of the intended surrogate for a reasonable period of time prior to insemination.

3. Screening of the intended couple similar to the adoption statutes prior to insemination.

4. No payment to the surrogate for selling or purchase of children only expenses incurred.

5. Licensing, screening and regulating of any clinics which are involved in surrogate parenting, including the centers which are to test and inseminate the biological mother.

6. The adoption of ethical guidelines formulated by the American Fertility Society, wherein fertile women would not be able to use the surrogacy process as a substitute for pregnancy.

The Bill before you does not contain many of these proposals. There is no period of time after the child is born for the mother to change her mind and I believe that pre-birth or at birth termination, is a termination without an informed consent. I use the words informed consent to mean a full understanding of the personal psychological consequences at the time of surrender of the child. One of the basic requirements of the validity of a surrender has consistently been that it cannot be given any effect if it occurred prior to the child's birth.

With regard to psychological counseling of the intended surrogate, I believe that the Bill does address that.

There is no requirement for screening of the intended couples in this Bill. Look at the possibilities, in a recent case involving a couple from Rochester, New York, in which an infertility center was involved. A transsexual couple sought to use the surrogacy process to have a baby for themselves. Since they could not have a child on their own and since they would not pass muster in an adoption agency, they used the surrogate process to get around the safeguard which society has placed in the screening process to have a child under the adoption statutes. Whether or not the court will allow such a couple to have a surrogate child, may be a constitutional question. However, people who do not pass muster or cannot have a child on that basis, should not be able to use the surrogacy procedures to buy a child. What if a child molestor decides he wants to buy a child?

Furthermore, I believe that payments to the surrogates over and above the normal expenses should not be allowed. There are no wealthy surrogates. If you look at women who present themselves to be surrogates today, you will find that the majority of them are the middle or lower class women. What has occurred in this area is the economic oppression of the poor by the wealthy or upper middle class. In the essence we are talking about buying and selling babies. The opponents of surrogate parenting argue that this is not a baby buying or baby selling but payment for a service. Again, I address to you the issues of stillborn and miscarried children. Is that not a service in which full compensation is entitled to be paid? A careful look at the contracts will show you that that is not the case.

With regard to the screening of clinics and laboratories involved in this surrogacy process, I find that the Bill does address that area and provides that it must occur in a licensed health care facility. You must police the clinics and laboratories or you will have reoccurrence of the many problems in this area. But you do not provide for the screening of the spem donor for sexually trasmitted disease in the Surroate Parenting Bill (A-3038), only in the artificial insemination Bill.(A-3037).

In addition, the Bill does not prohibit the baby brokers from making this a commercial venture. If you pay a reasonable compensation to somebody for his or her service rather than one of these $10,000.00 non-refundable fees to these baby brokers, you will be doing a service to society. Commercialism and exploitation by these people have caused them to become very wealthy. One can multiply the 150 births of the Infertility Center of New York by $10,000.00 and see that 1.5 million dollars has been amassed in the brokering of babies. An additional 135 babies are on the way, becoming another $1.3 million dollars. Should this be allowed in New Jersey, I think not.

To breifly address the various Bills that you have before you today, I would state that I have been following most of the Bills which have been proposed in New York and recently State Senator Marchi proposed a Bill similar to AJR-76 to create a commission to study and make recommendations regarding Surrogate Parenting. This topics is so encompassing that a study of the area is necessary. The Ethics Committee of the American Fertility Society in their September 1986 Report state that "..The Committee has serious ethical reservations about surrogacy that cannot be fully resolved until apporpriate data are available for assessment of the risks and possible benefits of this alternative". A full study of the issue without political pressure would be be in the best interests of all concerned.

Bill A-3036 which require insemination by a licensed physician is in conformance with the trend in the country requiring physicians to be involved in this process.

Bill A-3037 which requires the Department of Health to keep records of semen donors is also a step in the right direction. As of now it would be possible for two different women to be artificial inseminated by the same semen donor and the children produced might unknowingly marry, even though they have the same common father.

I have already commented on Bill A-3038, but Bill A-3039 is mind boggling. We are now legislating property rights to frozen embryo's. If this isn't the beginning of a Brave New World, I don't know what is. The new afterbirth provision is interesting. I'm not sure why custody of the frozen embryo should go to the female in the first instance.

I thank you for your time and am ready to answer any questions you might have.

In the Matter of Baby M)
a pseudonym for an actual) Supreme Court
person) of New Jersey

DIGEST OF AMICUS BRIEF OF FOUNDATION ON ECONOMIC TRENDS ET AL.

Introduction and Summary

It is a longstanding principle of Contract Law that no contract can be sustained if it is inconsistant with the public interest or detrimental to the common good. On this basis New Jersey courts have consistently refused to enforce contracts which violate the State's tenets of sound public policy.

An essential element of the public ,policy analysis is that it be forward looking. Therefore the judicial enforcement of a contract must be viewed in the context of the precedent it will create for enforcement of similar contracts in the future. Thus courts have held contracts invalid because enforcement of such contracts in the future would lead to circumvention of statutes, violation of basic concepts of justice and morality, and promotion of discrimination and exploitation.

While all contracts are subject to this public policy analysis, special scrutiny is mandated when the contract to be enforced is for a personal service. Despite the trial court's finding that the surrogacy contract involved a "totally personal service", the court makes no attempt anywhere in its opinion to make a thorough forward looking, equitable, public policy analysis of the results of enforcing surrogate mother contracts.

This friend of the court brief will put the issue of the long range public interest of enforcement of the surrogate mother contract in context with the revolution which is taking place in reproductive technologies and the genetic sciences. Without an analysis of the surrogate mother contract which includes the unique advances taking place in technology, the public policy considerations of enforcement of surrogacy contracts cannot be adequately examined.

The public policy question properly before the court is what effect advances in such technologies as embryo transfer, in vitro fertilization, genetic engineering of fetuses, fetal surgery, and gene mapping and sequencing will have on society should contracts similar to the one here at issue be enforced. At the outset it should be noted that the surrogacy contract itself relied on the use of several reproductive technologies including artificial insemination and amniocentisis.

This brief will maintain that, given this technological milieu, the enforcement of this contract and those similar to it will lead to the full scale commercialization of womens' reproductive organs and genetic makeup, reducing women to what the trial court termed "alternative reproduction vehicle[s]," this in turn could increasingly promulgate class differentiation and exploitation of disadvantaged women and families, with the creation of essentially a caste of breeders among the poor women of this country and the world. Moreover enforcement of surrogacy arrangements will lead to the revitalization of eugenics as acceptable public policy as babies are sold and bartered ultimately on eugenic grounds. Other adverse effects on society of surrogate contracts include the total alteration of parent child relationships, disruption of familial ties, circumvention of state and federal statutes, and deterioration of traditional and constitutional concepts of privacy and human dignity.

Background

We are presently experiencing a dramatic revolution in biological and reproductive technology. It has been less than a decade since the first "test tube" baby was surgically extracted, less than five years since the first successful "flushing" of an embryo from one womb and the placement of it into another, and only recently have we witnessed development of sophisticated techniques for embryo freezing for later transfer. Breakthroughs in cloning, fetal surgery, including genetic engineering of fetuses, are imminent.

The last few years have witnessed dramatic increases in the ability to isolate and identify elements of the genetic code, leading to the current billion dollar proposed project of sequencing the entire human genome. The implications of this influx of available biological information gained through the continuing identification and sequencing of the human genome are staggering. Hereditary defects may be able to be diagnosed in fetuses. Predisposition to a large variety of physical and mental diseases will be capable of early detection.

The rapid development of these sophisticated technologies has outdistanced the ability of society to adequately prepare for their introduction. Legislatures, courts, and the population in general find themselves spectators rather than participants in the development of these technologies. Troubling questions of law and public policy often must await a sufficiently publicized 'test' case before being addressed by legislatures.

In the lag time between the development of a technology and the clarification of the legal issues surrounding it, commercialization of the techniques begins. Complex legal and public policy questions concerning genetic screening, the status of frozen embryos, and in the present case surrogate contracts remain open despite the initiation of commercial exploitation of the new techniques.

The trial court recognized the rapid development of reproductive technologies and the dearth of legislation regulating these technologies. However, the court viewed only the "awesome opportunites" that these techniques create, the relief they offer to infertile couples, and the continuing "transformation of the family" that is resulting. Nowhere does the court adequately address the potential adverse impacts on society which the commercial exploitation of these techniques could cause; commercial exploitation which is feasible only through the enforcement of contracts such as the surrogacy contract upheld by the trial court and here at issue.

The Surrogate Contract

The Surrogate Parenting Agreement signed by Mr. Stern and Mr. and Mrs. Whitehead provided that for $10,000 and her medical expenses Mrs. Whitehad submit to psychiatric examinations, artificial insemination attempts as neccessary, and amniocentesis and other intrusive medical procedures; further Mrs. Whitehead was to assume the entire risk of pregnancy and child birth, carry the child to term unless it had congenital abnormalities in which case Mr. Stern had the option of mandating abortion, and after conception surrender the child to Mr. Stern and terminate all her parental rights.

In the case of a miscarriage after the fifth month or a stillbirth Mrs. Whitehead was to recieve $1,000. In the event of Mr. Stern's death prior to birth of the child, the child would be placed in the custody of Mr. Stern's wife. Mrs. Whitehead did not consult counsel prior to signing this agreement.

The major public policy objections to this agreement asserted at the trial were that the contract exploited the surrogate mother, denigrated human dignity by permitting the sale of a child, allowed an elite economic class to exploit a poorer group as breeders, disrupted family relations, threatened the newborn, and was contrary to state laws and the Constitution.

With minimal and misguided analysis the trial court dismissed these objections to the contract. With the exception of the abortion provisions the court below held the contract to be enforcable. The trial court held that despite all objections the contract was valid in that "[T]he male gave his sperm; the female gave her egg . . . thus, a contract."

Public Policy Analysis

The trial court erred in dismissing the public policy objections to the contract. The public policy concerns asserted on behalf of Mrs. Whitehead provided a sufficient basis for a finding that the contract she signed with Mr. Stern was unenforceable. Moreover, these public policy objections become clearly dispositive when the enforcement of this contract is viewed in historic context as a crucial first step in the "Brave New World" of the wholesale commercialization of the rapid developments in genetic and reproductive technologies. The trial court noted the ongoing revolution in reproductive technology but failed to expand the scope of its public policy analysis to include the consequences of enforcing the surrogacy contract within this fast emerging technological environment.

a. The surrogate arrangement exploits surrogate mothers

The State of New Jersey has consistently protected the rights of parents. State statutes do not allow termination of parental rights except as established in a formal hearing. Surrogate mother contracts are invalid because they force a mother to consent, out of court, to terminate her parental rights. Such a decision is too momentous to be made in this informal commercial contract setting and before the birth of the baby.

These state statutes are not situation-specific but apply to any termination of parental rights for whatever reason in whatever context. Thus it is not dispositive to contend, as the trial court does, that surrogacy was an unknown phenomenon when these statutes were enacted. Protection for parental rights was intended to apply to any situation in which a parent consents to terminate her parental rights.

Moreover, such consent is so carefully guarded it can be revoked even after being lawfully given in the adoption circmstance. Mothers who have given consent in adoption proceedings to terminate their parental rights have been allowed after several months to revoke that consent. Surely what is possible in the lawful context of adoption should be equally possible in the potentially illegal context of surrogacy agreements. In fact, in the three cases where courts have considered surrogate contracts, consent to terminate the mother's rights have been held to be revocable, and the surrogate contract voidable or void.

Additionally, if the termination of rights for surrogates who are biological mothers is upheld, then surrogates who are not genetically related to the surrogate child but are gestating the embryos of others will clearly have even less right to retain their offspring.

The incentive for surrogate mother's to terminate their rights is primarily economic. Studies have demonstrated that without the economic incentive the vast majority of potential surrogate mothers would not have agreed to the surrogate arrangement. This is true despite the unconscionably small remuneration paid, to the surrogate, generally around $10,000.

Apparently, even this price is too high. Thus John Stehura, president of the Bionetics Foundation, Inc., which helps arrange surrogate transactions has predicted that once surrogate contracts are held to be legally valid, corporations like his can recruit poor women both in this and Third World countries for a fraction of the current $10,000 fee.

If contracts such as that between Mrs. Whitehead and Mr. Stern are upheld it is clear, given the continuing revolution in such technologies as embryo transfer and in vitro fertilization, that a caste of breeders will be created from the poor women of this and third world countries. Under the guise of consent, economically disenfranchised women will be physically and emotionally exploited in a way unique since the abolition of slavery. Whether used as biological surrogates, carriers of the embryos of others, or sources for fertilized embryos, these women will be reduced to the status of alternate reproduction vehicles, a status given legal approval by the trial court. In exchange for a commercial fee this new caste of women will be simultaneously deprived of their parental rights and their humanity.

The trial court justified this new form of exploitation by comparing surrogate mothers with sperm donors. This comparison is disingenuous. The act of donating sperm pales in contrast with the nine month gestation and birth of a child, or the array of medical and psychological procedures to which the surrogate mother is subject.

Federal laws, such as those regulating the sale of organs for transplant, establish public policy that certain services cannot be for sale, that economic need of an underprivileged class cannot be used by an elite economic class to obtain organs for transplant, that contract law cannot and should not be extended to all human activities. While the donating of organs for transplant or research is acceptable, sale and commercialization is not; even though the need for such organs may be great. Similarly the donating of women of their bodies in order to bear a child for others may be acceptable, the sale and commercialization of these reproductive services is not; even though the need for such child bearing services may be great.

As the trial court noted, the revolution in reproductive technologies offers many opportunites, as do the techniques of organ transplant. As long as the development in reproductive technologies remains outside contract law and the realm of economic exploitation, these techniques can continue to offer some benefit to society. However, should contracts such as the one here at issue be enforced, the floodgates to commercialization of these technologies will be opened and a unique and tragic form of slavery over women will be legally authorized.

b. The surrogate arrangement promotes baby-selling and revitalizes the practice of eugenics

Surrogate mother contracts are void because they promote baby-selling, denigrate the value of a child's life, and revitalize the discredited practice of eugenics. The public policy against baby-selling is reflected in the statutory schemes of every state. These states prohibit any payment for a baby in the adoption context.

Although these statutes refer explicitly to the adoption, the policies that underlie them extend with equal force to the surrogate mother arrangement. No surrogate mother contract could be finalized outside the adoption process. For example, the trial court expedited adoption of Baby M by the Sterns immediately after its ruling.

The statutory prohibition on baby selling is designed to prevent the exploitation of children. It is clarly not in the best interest of the child to be a bartered object sold to the highest bidder. Despite the assertions of the trial court, the surrogate arrangement constitutes baby-selling. The contract itself establishes that it is the child, not just gestation, which is being sold. Should the surrogate not give birth to a living child, but still undergo the full nine-month gestation period, she receives but a small fraction of the $10,000.

By putting a price on a baby, the surrogate contract distorts and perverts the value of that baby, and of life itself. Legal precedent and traditional ethics establish that a baby is priceless. When children created by surrogate arrangements become aware of their origin it is expected that the commercial arrangements surrounding their birth will cause unique emotional problems. Moreover, contracting for children disorients siblings in the surrogate mother's family. After being exposed to the selling of the surrogate baby, several siblings have expressesed fears that they to may be sold or given away by the surrogate mother. The trial court refused to give any weight to testimony on the reaction of Mrs. Whiteheads children to the surrogacy arrangement.

Finally, the baby-selling nature of surrogacy will become even more pronounced as advances continue to be made in identifying, sequencing, and mapping the human genome. If courts rule that surrogacy and other alternate reproduction contracts are enforcable, the doors will be open to full scale commercialization of reproduction technology. In this market situation surrogate mothers will be genetically analyzed and screened. Their genetic make-up will be shown to the perspective buyers of the baby. Surrogate mothers with "superior" genetic traits will draw higher prices than those with "inferior" traits.

In short, the commercialization of surrogacy along with advances in genetic science and technology will lead to the revitalization of eugenics. This practice of "positive" eugenics, the pre-selection of children with traits thought to be superior, has been condemned since its use by the Nazis and been legally disfavored by courts, including the Supreme Court, since the Second World War. The fact that in surrogacy eugenics will now be practiced for commercial gain makes it even more insidious and potentially widespread.

In all eugenics movements the traits thought to be superior inevitably mirror the social and economic stereotypes and prejudices of any given society. Such eugenic practices tend to encourage and enforce prevailing forms of discrimination and exploitation.

The commercialization of reproductive technologies such as in vitro fertilization and embryo transfer will also lead to increases in the sophistication of eugenics techniques as consumers demand more "perfect" babies. This will undoubtedly include techniques such as sex selection (studies show a marked preference for sons), which would increase imbalance in male-female ratio. Further, with the new technologies now becoming available, including fetal genetic analysis, screening, and surgery, pressures to abort or change a fetus on eugenic grounds will be very strong in the surrogacy circumstance.

c. The surrogacy arrangement will be destructive of family ties

The trial court comments that the new reproductive technologies are causing a revolution in family relationships. The court itself views the enforcement of the contract as a prerequisite to the success of this revolution. Unfortunately the court did not examine the precise nature of the revolution it was fostering through its decision. Experts cited by the court make it clear that the family of the future could be created through an extraordinary specialization and segmentation in childbearing. For example, customer couples can contract and pay one woman to produce the egg, another to bear the child, which will subsequently be adopted by the wife of the natural father. Segmenting procreation into a series of technologically designed tasks reduces childbearing to the same kind of specialization and division of labor that characterized the factory system of production.

"By fracturing the mother-child relationship, society creates a new and more virulent form of social alienation that will affect all future generations. The destruction of the mother-child relationship is accomplished without being counteracted by any guaranteed social good beyond the convenience or wishes of those who can afford surrogates. As the trial court recognized, the basis for surrogacy contracts need not be infertility but can be based any grounds that the customer couple deems relevant.

Under the court's analysis the only law governing these arrangements is the law of the marketplace. The question of introducing contract law into the childbearing process requires an informed public debate and appropriate deliberation and resolution at the legislative level. Decisions of this magnitude should not and cannot be left to the discretion of courts.

d. The surrogacy arrangement violates the constitution.

The court attempts to create a new constitutional right for couples who wish to have another woman bear their child. The constitution contains no such provision. The privacy and procreation rights which courts have held to be constitutionally valid have not included the right to contract for the gestation and sale of children. To the contrary the court has consistently held that the mother carrying the child has the unique right to govern the nature of her own pregnancy, without state interference up to the time of viability. The court's holdings guaranteeing privacy affect and protect the individuals' choices on procreation, nowhere do they create a contract right to allow one person's procreation right to totally subsume anothers.

The courts constitutional analysis upholding the contract is thus fatally flawed.

Conclusion

For the foregoing reasons the surrogacy contract between Mrs. Whitehead and Mr. Stern should be declared void as contrary to public policy.

Respectfully submitted,

Foundation on Economic Trends

PREPARED STATEMENT OF SUSAN G. MIKESELL, PH.D., PSYCHOLOGIST IN PRIVATE PRACTICE, WASHINGTON, D.C., ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

I am Susan G. Mikesell, Ph.D., a psychologist in private practice in the District of Columbia. I am a registered nurse in the District of Columbia and serve as chairperson of the task force on Psychology and Nursing for the Divisions of Psychotherapy, Independent Practice and Family Psychology of the American Psychological Association. I am past-president of the D.C. Chapter of RESOLVE, the self-help organization for infertile persons and currently serve on the Advisory Panel of the Office of Technology Assessment study on Infertility Treatment and Prevention. I have counseled couples facing the crisis of infertility since 1982 in my capacity as a private practitioner doing individual and couple counseling. One-third to one-half of my practice consists of persons coming to me to help them sort out their feelings and assess the options available to them related to their infertility. I also am the consulting psychologist to an In Vitro Fertilization (IVF) Program where I meet with couples before the procedure to assess their coping skills and help them understand what stress will accompany this procedure. I see them after the procedure to help deal with the responses to the frequent failures and to assess what if anything to do next.

It is primarily from the perspective of the private practitioner and consultant that I would like to present what I have observed to be the psychological concomitants of infertility and the IVF experience. These observations are not unique to me. Other psychologist and mental health professionals who have worked in the field of fertility treatment have also described these phenomena. The self-help organization for infertile persons, RESOLVE, also reports similar observations.

The impact of infertility on an individual, couple, and extended family can be overwhelming. This reaction is not necessarily only experienced by a few. People expect when they have decided they are ready to have children they simply have to stop interfering with a normal process. When pregnancy does not occur within a reasonable period of time the question that there may be a possibility of pregnancy not happening becomes more than hypothetical. In this age of technological medical practice the more sophisticated individuals seek out the reproductive specialists for answers. The less aware individual goes to her gynecologist or clinic looking for a treatment or at least an answer for why this is happening. (Usually the woman addresses the possibility of a problem first).

Many diagnostic tests may be performed, leading to possible treatment strategies. All of this is tedious, time consuming, invasive and frequently humiliating. Normally, persons do not have to indicate on a chart every time they have intercourse with there partners and then present it to a physician for evaluation. For some infertility couples this charting procedure alone can destroy any sense of intimacy and may interfere with a primary means of feeling loved and cared about within a relationship. Sexual difficulty that results from infertility is an important psychological issue but not the only significant one.

When an individual comes to my office frequently the precipitating factors include an inability to function normally in other aspects of their life because the infertility interferes with those functions, or having "crazy" feelings that they have never previously experienced. It may be that they are significantly depressed or angry much of the time. These feelings interfere with the relationships with partners, friends, and family and with functioning appropriately in the work environment. They may find themselves unable to control their emotional responses in particular situations, i.e. feeling upset when a co-worker tells them she is pregnant, not wanting to go to the favorite beach because seeing the children playing now makes them feel resentful and sad, hearing someone glibly say they only need to "relax" and they will get pregnant and wanting to yell "You don't know what you are talking about!"

This sense of lack of control over their reproductive life becomes generalized. It thus becomes difficult to make any decision. The decisions affected are not only those about fertility treatment. They also include questioning taking the new job for fear of losing the insurance coverage. Purchasing a new house becomes a choice between paying for four IVF attempts or making the down payment. Can they request the new assignment that entails some out of town traveling when ovulation is likely to occur when one partner is out of town. Productive, competent individuals begin to appear to themselves and others as losing the one thing that had helped to make them feel secure. A generalized sense of low self-esteem and depression easily begins developing in this uncertain environment.

The medical choices are no easier. They include the decision to move from trying to conceive without medical intervention, to seek medical assistance to discover the problem, to utilize the more controversial technologies, to adopt, to live child-free, to stop treatment. Obviously every couple does not have to make every choice presented. Any one of these decision places the couple in a difficult situation. Take, for example, the decision of utilizing In Vitro Fertilization. First, each individual in a couple must deal with the loss and trauma of infertility at his or her own pace. This inevitably means that when a decision is being made there is an imbalance present. One partner needs to wait for the other to be ready to deal with the available options. If one member of the couple has strong reservations about the utilization of a particular approach to creating their family, that option cannot be discussed as a realistic option. For IVF, money and age are critical factors as well. Some couples cannot take advantage of the new technologies because they do not have the financial resources. While finances may not appear to be a psychological issue, one's economic status does effect how they perceive their self worth in this culture.

As a private practitioner and consultant to one IVF program, my ability to provide assistance to infertile persons is necessarily limited. Infertile people need to know that their needs are being taken seriously. This includes making sure that they are not exploited because they are so invested in wanting a family. We need wider dissemination of information on the normal psychological reactions to infertility to infertile persons and to persons working with them, particularly in the health field. There is a need to provide more adequate support to persons in our culture who are experiencing loss.

In conclusion, I would like to urge the Committee that as they look at practices such as IVF and Surrogate Parenting they remember that this is only one decision that many infertile persons may never have to reach. Most persons trying to have a child find themselves struggling with pain and anguish in isolation and desperately would like to be acknowledged as experiencing a legitimate loss. It is important to keep in mind all individuals who are effected by infertility when making any recommendations about selected treatments.

I thank the members of the Select Committee on Children, Youth and Families for this opportunity to provide testimony. Please feel free to call on me if I my answer further questions.

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